

# The Boston Medical and Surgical Journal

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## Original Articles.

### A NOTE ON JOHN HUNTER AT OXFORD.\*

BY HENRY VIETS, M.D., BOSTON.

"THEY wanted to make an old woman of me, or that I should stuff Latin and Greek at the University; but," added he, significantly pressing his thumb-nail on the table, "these schemes I cracked like so many vermin as they came before me." (Hunter to Sir Anthony Carlisle.)

So spake John Hunter late in his life as he reflected on the couple of months that he spent at Oxford. Such a forceful sentence is characteristic of him; it is inconceivable that he could have spoken otherwise. His whole life prior to 1775, when he went up to Oxford from London at his brother William's suggestion was hardly preparatory to Oxford idealism.

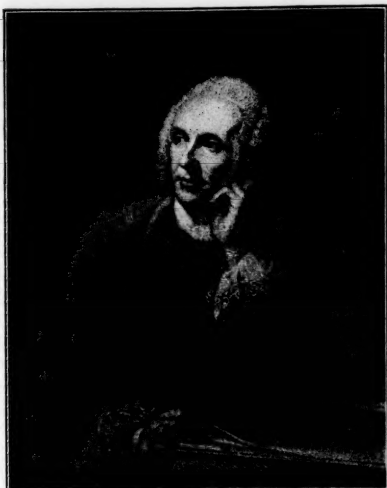
As a raw Scotch boy at his home in Long Calderwood, Lanackshire, he was near enough to have followed his older brother, William, ten years his senior, to the University of Glasgow, hardly more than a ten-mile walk, or to the consulting room of the genial William Cullen, a scant five miles to the south of his home in the town of Hamilton. Even Edinburgh, with the already famous Alexander Monro, 50 miles

away, had drawn William for a winter but failed to catch the younger brother. John knew none of these things. His childhood and adolescence were dream days, filled with rambles through the woods and vales observing Nature. "When I was a boy," he later said to himself, "I wanted to know all about the clouds and the grasses, and why the leaves changed color in the autumn. I watched the ants, bees, birds, tadpoles, and caddis-worms." Indeed this observation of nature was his life work. At 34 we hear of him in the army at Portugal, lying on the bank of a fishpond in a nobleman's garden, observing the fish swimming about and attempting in his own mind to note their organs of hearing. Much later in his life, when he was the leading physician of London, he had built for him a summer estate at Earl's Court, near the city, with a large zoo for the observation of animals.

The boy, then, whom we have seen wandering over the hills of Scotland, was crude, uncouth, and self-willed, a youngest son and "spoiled" by his mother. He was slow in learning to read and hated school-books. His letters all his life were full of errors of spelling and grammar, and yet this boy became the greatest name in Anglo-Saxon medicine.

So when this coarse but brainy Scotch lad of twenty, bred in the open, went to London

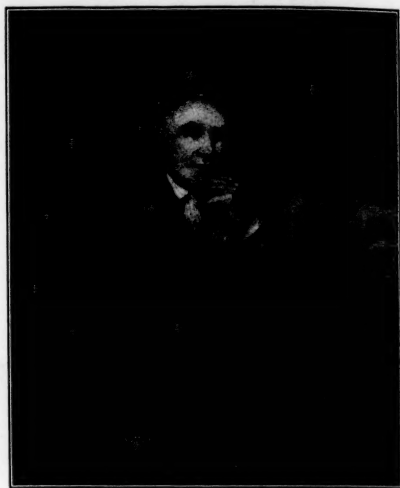
\* Read at a meeting of the Harvard Medical Society, January 6, 1920, Peter Bent Brigham Hospital, Boston.



*William Hunter.*

in 1748 to work with his polished brother William, is it any wonder that he was hidden away in William's dissecting room until he could be made into his brother's idea of a gentleman? John buried himself in dissection, "bore the rough work, hobnobbing with the resurrection-men, slaving all day long in unwholesome air." In the evening we must think of him either working or seeking recreation among the none-too-respectable class of resurrection-men of the Jerry Cruncher type or mingling "with the gods in the shilling gallery, for the purpose of assisting to damn the productions of unhappy authors, an office in which he is said to have displayed peculiar tact and vigor."

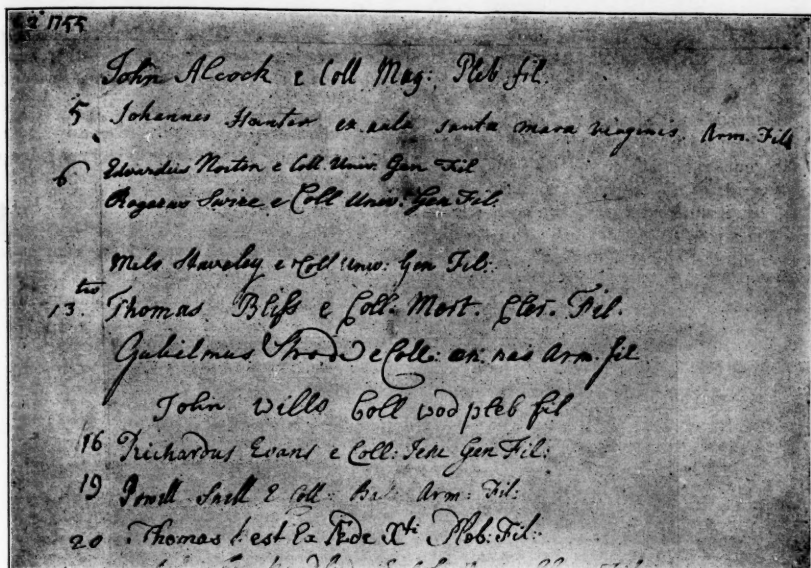
Let us look for a minute at the two brothers in the famous dissecting rooms in Great Windmill Street, London, on a winter's day in 1750. William is only thirty-two but has been in London nine years and giving lectures to medical students for six. John, now twenty-two, has been an apprentice to his brother only two years. These two men are far apart in temperament: William, the London gentleman physician, well dressed and with perfect manners, has a delicate, finely chiseled face and sensitive hands. He is best as a lecturer, clear, careful, and precise. One finds it difficult to think of him, with his lace cuffs and



*John Hunter*

velvet jacket, digging away at a dirty dissection. He already is well known and has an active practice, sometimes running away to see patients while John carries on the lectures and demonstrations. John is larger and more clumsy than William, though not quite so tall, his features lacking his brother's good looks, but his "whole face and figure are full of indomitable strength." William is physician-accoucheur to the Middlesex Hospital and surgeon-accoucheur to the British Lying-In Hospital, so he is glad to have John, a relentless worker, as his prosector. The work is rough, the air unwholesome and fatal putrid myasma by no means uncommon among anatomists. In this atmosphere the brothers work, John dissecting while William lectures and demonstrates.

After a year or two of the dissecting room, William began to "scheme" for John. He wanted his crude brother to become a gentleman physician, so he obtained leave for John to work with the kind and gentle Cheselden at the Chelsea Hospital. He probably worked as a surgical dresser and "walked the wards." When Cheselden died in 1751 John went as a surgeon pupil to Percivall Pott of St. Bartholomew's Hospital. He remained only a short



Page from the Registrum Subscriptionum, Bd. 7, Ad. An. 1740, signature is found. (I am indebted to the Keeper of the Archives,

Ad. An. 1776. Under the date of June 5, 1756, John Hunter's signature is found. (I am indebted to the Keeper of the Archives, Oxford, Reginald L. Poole, Esq., for permission to photograph this

time, and settled down to surgery at St. George's Hospital in 1754.

In 1755, when John was twenty-seven, William persuaded him to go up to Oxford, perhaps "to stuff Latin and Greek," but more probably to acquire the university manner, so essential, from William's point of view, for a gentleman physician. John matriculated on the fifth of June, 1755. Three years ago, while in Oxford, I found his name in the *Registrum Subscriptionum*, the book signed by all scholars on their entrance to the University. He was the only man to register on that day and signed a rough signature with obvious errors in the Latin, "Johannes Hunter, ex aula sanctae mariae virginis, Arm. Fil.," son of a family with an armorial crest. The book was closed before the signature was dry, perhaps with a bang, to show the registrar's contempt for Hunter's Latin.

He was in Oxford only about two months, as the last entry for battles against his name in the buttery accounts was dated the twenty-fifth day of July, 1755. His name, however, remained on the books until the tenth of Decem-

ber of the next year, but he certainly was not in Oxford during the spring and summer of 1756, for we know he was house-surgeon at St. George's from May to September. His college was St. Mary's Hall, a part of Oriel College, but run as a separate place of education. There were no matriculation examinations so John entered on a somewhat lower standard than students at other colleges. The Hall is no longer standing and as a college is now an integral part of Oriel.

So John Hunter "cracked the schemes" to "make an old woman" of him and came back to London to continue his career in more productive fields. William took him back and did not lose faith. John said afterwards, when accused by a friend of not understanding the dead languages, that he "could teach that on the dead body which he (the friend) never knew in any language, dead or living." The scheme fell through; no harm was done, and 165 years later it merely serves as an interesting note on the characters of William and John, the gentleman physician and the master physiologist, surgeon, and scientist.

# FRACTURE OF THE POSTERIOR TUBERCLE OF THE ASTRAGALUS VS. INCONSTANT OS TRIGONUM.

BY FREDERICK W. O'BRIEN, M.D., BOSTON.

THERE is a paucity of exact literature regarding the genesis and nature of the inconstant supernumerary ossicle sometimes found on the outer side of the posterior external tubercle of the astragalus and known as the os trigonum.

When seen on roentgen examination in the absence of clinical symptoms or history of injury its discovery may be only of academic interest.

However, with presenting symptoms localized or referable to its anatomic situation its presence gives rise to the query whether we are dealing with a fracture or the processus posticus tali or an anomalous marsupial remnant.

Furthermore, clarity in diagnosis is not helped by our present uncertain knowledge as to whether or not the posterior external tubercle is in reality nothing but a union of the epiphyseal os trigonum with the astragalus. If we accept the os trigonum as a mammalian vestige that remains distinct from the astragalus, then it is evident that many authors, when



FIG. 1.—Left foot, July 21, 1919, showing fractured posterior tubercle.

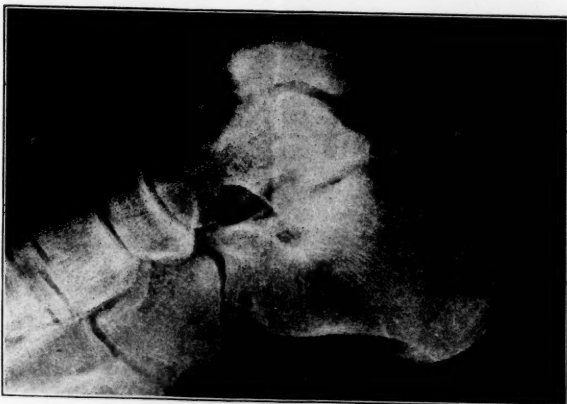


FIG. 2.—Right foot, July 21, 1919, showing apparently normal astragalus, well developed posterior tubercle, no evidence of separation.





FIG. 3.—Left foot, Aug. 13, 1919, showing apparent union of fractured posterior tubercle.

writing of fracture of the os trigonum have really meant fracture of the posterior tubercle of the astragalus.

Finding, on roentgen examination, what appears to be a separate ossicle in the region of the posterior lateral tubercle in one foot and not in the other has been advanced by some as proof that one is dealing with a genuine os trigonum. This may be accepted, provided it is not found in the clinically sick member and that there is no previous traumatic history connected with the supposedly well foot.

Roentgenologists continually observe this questionable anomaly without the reflection I believe it deserves. The following case presented some unusual features which led to this study.

George M., aged 23, was referred for x-ray examination of his left foot and gave a history at the time of pain in the region of the ankle joint and of having come down hard on his heel, twisting his ankle, some time previously. He was definitely tender to palpation just posteriorly to the external malleolus. X-ray examination was made of both feet on July 21, 1919, and a report made to his physician of fracture of the posterior tubercle of the left astragalus. Attention was called to the possibility that what was thought to be a fracture fragment could be the inconstant os trigonum. The right foot was normal and showed a well developed posterior tubercle. Because of his clinical symptoms and the x-ray findings, it was advised that the case be treated as a fracture. The foot was put in plaster.

On August 13, the patient was reexamined and a report made of "X-ray evidence of union of the fractured astragalus." October 21, 1919, the patient was referred for x-ray examination of the right foot and presented the clinical signs of pain on walking and pain on palpation in the region of the external malleolus but could not remember any injury. What appeared to be a fracture of the posterior tubercle of the right astragalus was found and so reported to his physician, who placed this foot in plaster.

On November 19th the patient returned for examination and the x-ray report read "Fracture of the posterior tubercle of the right astragalus, ununited. No evidence of separation of recent fracture fragments of left foot."

From further study of the plates of this case and of the literature, I am convinced that in the first instance there was a definite fracture of the posterior tubercle of the astragalus in the left foot and in the right foot a separation of an os trigonum from its cartilaginous attachments.

If the os trigonum is a separate entity and not an epiphysis, then the failure to have demonstrated it on the first examination in the right foot may have been due to the extent and closeness of its cartilaginous attachments which were later separated by slight injury although the matter of roentgen technic should not be overlooked, for unless the angle of rays is correct there might well be an overlapping of structures which would preclude proper definition.



FIG. 4.—Right foot, Oct. 21, 1919, showing fractured posterior tubercle, epiphyseal separation or inconstant os trigonum? (See Fig. 2.)

Anatomists who insist very strongly that the os trigonum is not the same thing as the tubercle say it may represent practically the whole of the external posterior process, that it may be truly fused with the astragalus or closely joined by synchondrosis.

Dwight describes the hind part of the astragalus as being drawn out backwards into a projection, grooved by the tendon of the flexor hallucis muscle, which runs obliquely downwards from without inward. The outer border of this groove is made by the posterior external tubercle. The inner border may be very ill defined or may be marked by the posterior internal tubercle. The external tubercle on the outer border of the groove has not the slightest mechanical function unless perhaps that it prevents the tendon from falling outwards during the total relaxation of the muscle. Certainly when the muscle is contracting the tubercle is of no value. On the outer side of this tubercle is the trigonum, which, he says, in some seven or eight per cent., is a distinct bone. Its lower surface continues the articulation of the astragalus with the os calcis.

v. Bardeleben found it a distinct piece of cartilage in the second month of embryonic life, situated between the bones of the leg and therefore homologous with the triangulare. Dwight found it distinct in cartilage at birth and writes that it is hardly found in animals except in the marsupials and is constant in those of that order which have five toes. It is very variable in size and development. Very rarely it is found in two pieces. When it is free it is generally joined to the astragalus by a little fibro-cartilaginous tissue, the bony surfaces being in close apposition, exceptionally there may be a true joint. Sometimes the union may be by cartilage. When it is truly fused so that there is but one bone, the outline of the trigonum may be perfectly clear or very hard to make out. The trigonum tends to be in the main symmetrical but may be distinct on one side and fused on the other. Fused though clearly marked off trigona may be easily overlooked and a free one may be so closely joined by synchondrosis as not to be recognized without great care.

Skellern states that the os trigonum was first

described by Rosenmuller in 1804, that normally it remains independent for only a short time, uniting to the astragalus, and that only in some three per cent. of cases it persists as an independent bone. Aside from man, it is found among mammals only in the wombat. He further declares that it is present on both sides and has the peculiarity of being usually rudimentary on one side. He quotes Stimson to the effect that fracture of the processus posticus tali was first mentioned by Cloquet in 1844. Lilienfeld in some six hundred fractures observed by him at the Zender Institute saw seven isolated fractures of the posterior tubercle and five in conjunction with fracture of the calcaneum. It is pointed out that Stimson and others confuse fracture of the posterior tubercle with the inconstant os trigonum. Thus Stimson quotes Lilienfeld as having observed twelve fractures of the os trigonum 'whereas a reference to this article shows that it was the processus posticus tali that was fractured.

Steeley consulted two hundred and fifty-six authors in a review of the literature on fractures of the astragalus up to 1909, but makes no mention of fracture of the os trigonum. Since that time x-rays have been employed with greater frequency and success and yet I have not been able to find anywhere in the literature any reference to fracture of the os trigonum as such.

If the os trigonum is only loosely attached or at other times fused with the astragalus, it follows that it might very well be pulled off by strain on the posterior bundle of the external lateral ligament of the ankle. If fused with the astragalus it could be separated by the same forces as fracture of the posterior tubercle, *viz.*, a fall upon the heel with the foot in plantar flexion. It seems fair to conclude the roentgenologist should make a closer study of this region in the presence of clinical signs.

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## THE PRODUCT OF A UROLOGICAL CLINIC.

BY WILLIAM C. QUINBY, M.D., BOSTON.

(Concluded from page 529.)

25. Man, No. 6806, aged 82, married, 29-v-17. Hypertrophy of prostate. Perineal prostatectomy. No evidence of malignancy. Three lobes enucleated. No excess of bleeding. Complications: Preoperative treatment for twelve days was complicated by inefficiency in catheter control. Fever resulted. Renal output continued adequate. Three days after operation broncho-pneumonia followed by death. Autopsy confirmed this diagnosis and showed acute fibrino-purulent pleurisy and infarction of the lung.

26. Man, No. 5874, aged 66, 9-xii-16. Hypertrophy of prostate. (1) Perineal prostatectomy. (2) Repair of rectal fistula. The rectum was entered on freeing tip of prostate. Operation closed this by diverting urine and local suture. No complications. Discharged well twenty-seven days after second operation. Result: v-19. Patient feels well. No urinary disturbance except nocturia once. Constipation. The rectum admits forefinger but the sphincter does not contract down. No incontinence of feces.

27. Man, No. 5142, aged 72, married, 26-v-16. Hypertrophy of prostate, median bar. Partial prostatectomy. Punch operation. No complications. Patient discharged six days after entrance. Result: 1-v-18. Operation relieved obstruction. Patient has since had acute gonorrhea; otherwise is well.

28. Man, No. 7803, aged 67, 6-xii-17. Hypertrophy of prostate. Chronic nephritis; inguinal hernia; cystitis. Suprapubic prostatectomy; removal of median bar. The obstruction was removed by three bites of tonsil punch. Complications: The patient's condition was increasingly uremic, beginning about one week after operation. There was gradual improvement due to hot air baths and forced fluids, and the patient was discharged about two months after operation in fair condition. Result: It has been impossible to trace the patient. Probably dead.

29. Man, No. 6675, aged 56, married, 1-v-17. Hypertrophy of prostate. Median bar. Suprapubic partial prostatectomy by excision of median bar. No complications. The patient was discharged on the twenty-first day after operation with wound healed. Result: 16-xii-18. Patient is well. Very rarely rises once at night to urinate. The urine is clear with a few shreds.

30. Man, No. 6417, aged 60, married, 13-iii-17. Hypertrophy of prostate. Suprapubic partial prostatectomy by excision of median bar.

Complications: Slight swelling of right leg. Patient was discharged on twenty-fourth day after operation. 1-ix-19. Has obtained an excellent functional result. Urine contains a little pus. No residual found in bladder. Has had one or two attacks of phlebitis with swelling of leg for which he wears an elastic stocking.

31. Man, No. 7070, aged 59, married, 19-vii-17. Prostatic obstruction from median bar, causing increasing pain and tenesmus, and finally acute pyelonephritis. Suprapubic cystotomy for relief of kidneys. Complications: Steady decline with high fever, hematuria and pyuria. Death ten days after operation. Autopsy: Showed bilateral suppurative pyelonephritis, and hypertrophy of the middle lobe of the prostate and broncho-pneumonia.

32. Man, No. 6786, aged 62, married, 24-v-17. Hypertrophy of prostate. Patient has been critically ill for eleven weeks before entering hospital; had had a slight paralytic attack which was followed by severe headaches, persistent hicough, and glycosuria. On 4-vi-17 the bladder was drained by suprapubic cystotomy to relieve the kidneys. Complications: Steady downhill course with death on nineteenth day. Autopsy: Showed bilateral pyelonephritis; aplasia of right kidney; hypertrophy of prostate and bladder; acute cystitis, subdiaphragmatic abscess (left) with hyperplasia and necrosis of the spleen.

33. Man, No. 6611, aged 66, married, 16-iv-17. Hypertrophy of prostate. Patient in very precarious condition. He was put on constant drainage by urethra, but his general condition steadily declined. Death occurred on twentieth day after entrance, with signs of extreme uremia. Autopsy: Showed hypertrophy of prostate and bladder; acute purulent cystitis; ureteritis and pyelonephritis; chronic nephritis and abscesses of kidney; emphysema of lungs.

34. Man, No. 6454, aged 59, married, 19-iii-17. Hypertrophy of prostate. Operation was advised but was refused. Renal function 60%. Urine not infected. Discharged 24-iii-17. Result: 28-vi-18. Urine normal. Condition no worse. Symptoms unchanged.

35. Man, No. 5519, aged 64, 5-x-16. Cancer of the rectum; hypertrophy of prostate; difficulty in urination. Condition not bad enough to warrant colostomy, although growth appeared inoperable. In view of malignancy elsewhere it was not deemed wise to attack prostate. Patient was discharged six days after admission. Result: Letter from son states the patient was operated on at another hospital, and died on 19-i-18.

36. Man, No. 5598, aged 61, 18-x-16. Hypertrophy of prostate; impending uremia. No

operation. Patient died two days after entrance. Autopsy: Showed pelvic peritonitis; myelogenous leukaemia; hypertrophied prostate with infection of bladder and kidney.

Of the cases of complete prostatectomy 16 were done by the suprapubic method and 10 by the perineal. There were three deaths, two in the former group and one in the latter. In Case 14 it was probably a mistake to subject the patient to further operation. His condition was deplorable and fast becoming worse, because the suprapubic opening made two months earlier at another hospital had been allowed to become so small that no relief to the obstruction at the neck of the bladder was afforded. Excessively painful urination prevented sleep without the aid of drugs. No phenolsulphonephthalein was excreted at all. The bladder was very septic. Cases 15 and 16 died of broncho-pneumonia. In the first instance this could not be accounted for by any condition at the site of operation; in the second, it is probable that local sepsis may have been the starting point of a more generalized infection.

Adding to these cases four of partial prostatectomy for median bar, the total number is 30, and the mortality of this group is then 10 per cent. It is to be hoped that this percentage of deaths can be reduced in later series of cases.

Case 6 teaches the lesson that a diverticulum may be overlooked even when the bladder is open to view, if it have a small orifice which becomes shut when the bladder is flaccid. Search for such condition should be most carefully made both on cystoscopy and at operation.

In Case 17, it is certain that a cancer of the prostate was overlooked. But the pathologist also failed to find cancer in those portions of the gland examined. The later clinical course of the patient, however, indicates clearly that death was caused by a spinal metastasis.

Cases 23 and 26 were complicated by a fistula communicating with the rectum; Case 24 by one persisting in the perineum. Each of these instances was the result of faulty surgical technic and therefore should be obviated. Their occurrence merely means that the perineal operation is more difficult in performance than the suprapubic. It certainly does not signify that the perineal operation is less good

for the patient if it be properly done. (For further information see: W. C. Quinby, "Standardization of Methods in Cases of Prostatic Obstruction," *Am. Jour. of the Med. Sciences*, 1919, Vol. CLVII, No. 3, p. 390.)

#### PROSTATITIS.

Man, No. 6006, aged 47, married, 3-i-17. Prostatitis with slight prostatic enlargement. Perineal prostatectomy. No line of cleavage. Enlargement mostly due to infection. Complications: Occasional slight fever. Discharged eighteen days after operation. 20-x-19. Result: Feels entirely well when he keeps bladder clean, which he has done by regular visits to Out-Door Department. Has a residual of about 10 or 15 cc.

#### GONORRHEAL PROSTATITIS.

1. Man, No. 5814, aged 32, 29-xi-16. Gonorrheal prostatitis and vesiculitis. Arthritis, double seminal vesiculotomy. Several incisions were made in each vesicle. Drainage by rubber tube. Complications: Wound of bladder caused slight leakage of urine which still persisted on discharge on twentieth day after operation. Result: 15-iii-17. Marked improvement in joint. Perineal sinus persists. Treat by dilatation of urethra. 12-iv-17. Patient still has a few drops of urine coming through sinus, although this is often dry for two or three days. No further data.

2. Man, No. 6678, aged 28, married, 1-v-17. Painful swelling of the left knee due to gonorrheal arthritis. Gonorrheal prostatitis and vesiculitis. No operation. Patient discharged after seven days, for treatment as an ambulatory case. Result: 29-vi-18. Patient is much improved. Has occasional perineal pain. The urine is normal. 14-vii-19. Patient still under treatment in the Out-Door Department for syphilis.

#### CANCER OF THE PROSTATE.

1. Man, No. 5394, aged 64, 13-ix-16. Cancer of the prostate, causing pain and frequency. Sufficient tissue removed by perineal route to free the neck of the bladder. Complications: Transient left pleurisy. Otherwise normal convalescence. Discharged twenty-second day after operation with wound healed and urination much less difficult. Result: Patient died in ix-17.

2. Man, No. 7533, aged 74, 16-x-17. Cancer of prostate, causing frequent, painful urination, together with sciatica, for which patient was compelled to use crutches. Radical operation out of the question. Suprapubic cystostomy for permanent drainage of bladder. Re-

sult: 1-xii-17. Condition surprisingly good: sciatica leaving. Confined to house, however. Catheter works well with practically no desire to urinate by urethra. Is slowly losing ground. 12-v-18. Is definitely failing. Bladder badly infected, but has no fever, and catheter works well. 17-xii-18. Has fair appetite: sleeps fairly well, and has but little "sciatica." He is recently having trouble with gas. Usually out of bed once each day. viii-19. Died.

3. Man, No. 7464, aged 76, 2-x-17. Cancer of the prostate which had caused complete retention during past two years. Patient uses catheter himself, and seems to tolerate it without much trouble. On rectal examination a mass was found bulging toward rectum which was almost pedunculated. It was impossible to pass a cystoscope to examine the prostate on its other surface. No operation advised, inasmuch as patient was very comfortable. Subsequent course: 27-iv-19. Writes from Florida, "Considering the ills which have menaced me for some years, I have had a remarkable winter." Patient's condition seems to be stationary, he having acquired resistance to the chronic infection of the bladder to a remarkable degree. It is not evident that the prostatic mass is increasing in size except very slowly. This can be judged by the fact that only recently patient has had to introduce catheter with a stylet, which has not been necessary before.

Case 2 illustrates well the slow progression which occasionally occurs in prostatic cancer. For almost two years the patient was kept entirely comfortable in so far as the bladder was concerned, by suprapubic drainage.

Case 3 has lived for considerably over two years in very fair general health, in spite of prostatic malignancy. For over four years all urine has been voided through a catheter. The wisdom of withholding operation can hardly be doubted in this instance.

#### HYDROCELE.

1. Man, No. 4843, aged 41, married, 5-vi-16. Inguinal hernia; left hydrocele. Excision of hydrocele sac with repair of hernia. No complications. The patient was discharged twenty-two days after admission. No further data.

2. Man, No. 5243, aged 35, 17-viii-16. Left hydrocele. Excision of hydrocele sac. Complications. There was considerable swelling for a period of twenty-one days. The patient was discharged twenty-one days after operation. No further data.

3. Man, No. 5700, aged 49, married, 8-xi-16.



Left inguinal hernia, and hydrocele of cord. Herniotomy with removal of hydrocele. Patient was operated on at the Massachusetts General Hospital on the 27-vi-16, by drainage of the bladder. Prostate stated to be normal. Their diagnosis was chronic retention of urine and cystitis. The urine still contains pus. Complications: A few minute stitch abscesses formed. Patient was discharged on the twelfth day after operation. Result: 6-xi-19. A letter from patient's sister states he is well and at work.

4. Man, No. 5786, aged 20, 24-xi-16. Hydrocele of cord. Excision of hydrocele with repair of external ring. Complications: Post-operative coryza and pharyngitis. Patient discharged fourteen days after operation. No further data.

5. Man, No. 5821, aged 51, 1-xii-16. Hydrocele. Radical operation for hydrocele. Bottle method. Second day after operation patient had fever and a chill, but temperature was normal the next day. The patient was discharged eleven days after operation. No further data.

6. Man, No. 6971, aged 32, 2-vii-17. Right inguinal hernia. Right hydrocele. Repair of hernia and excision of hydrocele sac. No complications. Patient was discharged on sixteenth day after operation. Result: 23-vi-19. Letter from patient states that he has been in excellent health since operation.

7. Man, No. 7517, aged 45, 12-x-17. Hydrocele. Excision of hydrocele sac. The sac was firm and fibrous. Complications: On the eighteenth day incision and drainage for hematoma was necessary. Patient discharged on the twenty-eighth day after operation. No further data.

#### VARICOCELE.

1. Man, No. 5241, aged 23, single, 17-viii-16. Left varicocele. Fistula in ano. Excision of varicocele and of fistula. Anterior group of veins involved. Ligatures of silk. No complications. Patient discharged on eleventh day after operation. Result: 30-iv-18. Doubtful if fistula is entirely cured. 2-v-18. Patient had a boil which broke near anus. Diagnosis: Subsiding furuncle. No fistula. Varicocele all right.

2. Man, No. 5370, aged 29, single, 10-ix-16. Left varicocele. Excision. No complications. Patient was discharged on the eighth day after operation. 28-vi-18. Letter answered by patient, who is in the Gas Defence Service in Washington. He states that very seldom does he feel pressure in the veins of groin similar to that experienced before operation. Testicle, however, is very hard. He is occasionally troubled with indigestion and constipation, and also distressed with swelling of the testicle and resultant pressure.

3. Man, No. 5695, aged 18, single, 7-xi-16. Right hernia and left varicocele. Repair of hernia and excision of varicocele. Complications: Unexplained fever for two days. Patient discharged on the fifteenth day after operation. Result: 29-xi-16. Patient has had no trouble since operation. Examination shows tight ring on the right. No recurrence of varicocele on left. No further data.

4. Man, No. 5847, aged 28, single, 5-xii-16. Left varicocele. Excision of varicocele, and circumcision. No complications. Patient was discharged on the seventh day. Result: 23-vii-18. Letter from patient's wife states that he is better, but when doing heavy work he has pain and swelling.

#### SEMINAL VESICULITIS.

1. Man, No. 5467, aged 34, single, 27-ix-16. Epididymitis and seminal vesiculitis. Hemospemia. Seminal vesiculectomy. Incision and drainage of tunica vaginalis. Complications: Fever, and recurrence of epididymitis. Discharged thirty-six days after operation. Result: 6-iii-19. Patient still complains of dull pain at the neck of bladder, and states that during defecation blood emerges from urethra. Cystoscopy. Bladder neck is very tender. Mucosa is normal, and the ureteral orifices are normal with clear urine coming from each. Subcervical region shows hemorrhage and exudation. There are fine pinkish-red corrugations in the prostatic portion of urethra. 22-vii-19. Patient says he feels much better. He has had lavage of bladder and prostatic massage once every two weeks. 26-viii-19. Patient says he feels fine. Urine clear. No pains except slight burning in bladder.

2. Man, No. 7445, aged 32, single, 28-xi-17. Long standing pain and stiffness in shoulder, knees, ankles, and spine, with marked limitation of motion. Chronic arthritis and seminal vesiculitis. Double seminal vesiculectomy. No frank pus found in either vesicle. No complications. Patient was discharged on eighteenth day with small sinus persisting. No special change in joints. Result: 30-vii-18. Patient writes that he has not been able to work since leaving hospital. His right leg was "drawn up." 2-vi-19. Reentry. Consultation with Dr. Z. B. Adams finds process in joints still active. 23-vi-19. Removal of prostate. Excellent convalescence. Patient discharged on twentieth day after operation. No immediate change in joints.

It is hard to believe that Case 1 would not have recovered sooner had less radical treatment been employed. Case 2 was a cripple when first seen. It is not yet evident that operation has been of any benefit.



## ACUTE EPIDIDYMITIS.

Man, No. 5743, aged 51, married, 16-xi-16. Acute epididymitis and non-venereal prostatitis. Epididymotomy. No complications. Patient was discharged seven days after operation. Result: 1-ii-17. Since leaving the hospital, patient's convalescence has been uninterrupted. He has been having weekly dilatation of the posterior urethra reaching size 35 F. and followed by AgNo, 1-5000 and massage of prostate. The urine is now free from shreds. The epididymis is almost normal in size and has lost its unusual tenderness. 1-i-18. The local condition for which I operated has remained well. Very rarely has slight irritability as though from prostatitis. Since last report, has had his appendix removed and is much improved.

## GONORRHEAL EPIDIDYMITIS.

1. Man, No. 5430, aged 23, 21-ix-16. Gonorrheal epididymitis. Incision and drainage of epididymis. No complications. Patient was discharged on the eleventh day after operation. Result: 16-vii-17. Has been under treatment in the Out-Door Department. Urine clear without shreds. No further data.

2. Man, No. 7701, aged 28, 15-xi-17. Gonorrheal epididymitis. Epididymotomy. No complications. The patient was discharged two days after operation. Result: 16-xii-18. Patient was entirely free from symptoms. Use of alcohol and intercourse brought no recurrence of trouble. Urine clear. 20-x-19. Patient stated that he was entirely well.

## TUBERCULOSIS OF THE EPIDIDYMITIS.

1. Man, No. 4755, aged 36, 19-v-16. Tuberculosis of each epididymis. Possibly tuberculosis of the prostate. Tuberculosis of the lungs. Right orchidectomy. The testicle and the epididymis were both involved and therefore removed. The vas was pulled down as far as possible and then cut off. No complications. The patient was discharged eight days after operation. Result: 20-ii-18. Patient states he has been well but is not as strong as before operation. Physical examination shows the left epididymis to be involved. Patient wears a suspensory and says testis gives no discomfort.

2. Man, No. 5010, aged 21, 5-vii-16. Question of tuberculosis of the epididymis. Epididymectomy. High incision. No tuberculosis found; disease evidently due to gonorrhea. The patient was discharged on the eleventh day after operation. Result: 14-v-18. Condition entirely normal.

3. Man, No. 5880, aged 27, single, 11-xii-16. Complaint: Swelling of the scrotum. Tubercular epididymitis and vesiculitis. Vesiclec-

tomy; vasectomy; epididymectomy; orchidectomy. No complications. The patient was discharged on the twenty-first day after operation. Reentry: 19-iii-18. One month before reentry the patient contracted gonorrhea. This caused epididymitis. The recovery from this attack was uneventful, and no evidence of recurrent tuberculosis was found. 1-v-18. Patient still under treatment in Out-Door Department for prostatitis. Reentry: 30-xii-18. Recently the epididymis has become more nodular and painful. The urine is slightly turbid. Epididymis excised. No complications. Patient discharged on seventeenth day after operation. At this time the ureters were catheterized and it was found that the urine from the right kidney contained tuberculosis bacilli. There was also evidence of tuberculosis of the bladder. It was not possible to catheterize the ureter on left side. 18-ii-19. Tuberculin treatment started and continued at intervals of twice a week, lasting through April. 17-v-19. Patient feels somewhat better but urine is still cloudy and there is frequency and occasional slight hematuria. Patient is evidently losing ground.

4. Man, No. 5920, aged 25, 18-xii-16. Tuberculosis of epididymis and vesicle. Vesiclectomy; vasectomy; epididymectomy. Not a great deal of perivesicular infiltration was found. Complications: Slight persistence of bleeding from perineal wound for several days. Patient catheterized for a few days after operation. Discharged sixteen days after operation. Result: 12-i-17. Patient came to Out-Door Department for treatment. The perineum was healed, and the scrotum nearly so. No difficulty in regard to urination. The urine was clear, with a few granular shreds, and was passed at normal intervals. 10-ii-17. Patient had gained eight pounds. The scrotal wound was not entirely healed. 10-iii-17. A sinus appeared in the perineum discharging a few drops of pus intermittently. 24-viii-17. The sinus remained closed almost entirely. The patient had been working and had lost weight. Was put on a course of tuberculin. 1-x-17. During summer vacation patient showed marked improvement. No further discharge from sinus. Gain of fifteen pounds in weight. 28-iv-18. Patient reported that although he had been working, his health had been excellent during past year. Examination proved both testes normal. By rectal palpation the prostate felt normal, but there was a small depressed area at its upper right side over which the rectal mucosa was puckered. Left vesicle could not be palpated. Urine normal in all respects.

5. Man, No. 6017, aged 28, married, 4-i-17. Tuberculosis of seminal vesicle and epididymis. Vesiclectomy; vasectomy; epididymectomy. The vas at the prostatic end was very fragile

and broke several times under moderate traction. No complications. Patient discharged eight days after operation. Result: 23-i-17. The wounds were solid. Patient soon gained weight. He was put through a course of anti-tuberculous hygienic treatment. 27-v-18. Patient came to report. He has been in excellent health since operation. Gained in weight. Has coitus three or four times a week, but wife has not borne a child for six years. Both testes small and somewhat atrophic. Rectal examination normal except for a few small adhesions of mucosa to underlying structures. No urinary symptoms. The urine is normal. Impossible to obtain prostatic secretion by expression for examination.

6. Man, No. 6595, aged 36, married, 12-iv-17. Tuberculosis of epididymis and vesicle; pulmonary tuberculosis. Epididymectomy. Vas cut off at external ring. No complications. Patient was discharged on sixteenth day after operation with sinus not healed. Result: 5-vi-18. Patient died early in 1918.

7. Man, No. 6698, aged 30, 7-v-17. Tuberculosis of epididymis and vesicle. Vesiculectomy; vasectomy; epididymectomy. Impossible to demonstrate any involvement of vesicle or prostate before operation. No complications. Patient discharged twelve days after operation. Result: 7-vi-18. Patient well. Sinus dry since previous October.

8. Man, No. 7468, aged 33, 3-x-17. Tuberculosis of epididymis and seminal vesicles. Left vesiculectomy; vasectomy; epididymectomy. On account of adhesions the whole of the vesicle was not removed. No complications. Patient was discharged one month after entrance. Reentry: 14-xii-17. Patient has had recurrence of tuberculous process on the other side; general condition bad, and lungs seem to have flared up. 19-xii-17. Right orchidectomy. Complications: Patient made a poor convalescence. Had hectic fever, especially at night, and did not react to forced feeding and anti-tuberculous hygiene. The sinuses were treated with bismuth iodoform petrolatum paste. Patient discharged forty-five days after operation with the sinuses still persisting. Result: 5-vi-18. Patient came to report that he was in a surprisingly good condition, having gained ten pounds since leaving hospital. There was a minute sinus in the right groin and one in the right side of the perineum, but these discharged so little that no dressing was needed. The urine contained a little pus by microscopic examination. Coitus was normal but there was no ejaculated fluid.

9. Man, No. 7266, aged 26, single, 24-viii-17. Bilateral tuberculosis of epididymis and vesicle. Bilateral epididymectomy; vasectomy and vesiculectomy. One side showed more acute process than the other. No complications. Patient was discharged on sixteenth day after op-

eration. Result: 3-vi-18. Patient is at work and in splendid health. Has gained in weight. Coitus normal but not as frequent as before. Testes are of normal size and freely movable in serotum. The cords are not thickened. By rectum the prostate feels normal. Rectal mucosa somewhat adherent. Urine clear.

10. Man, No. 7376, aged 39, married, 14-ix-17. Chronic epididymitis and chronic orchitis. No operation. Process improved in hospital, and after ten days patient was referred to the Out-Door Department for treatment of posterior urethra. Result: 28-ix-17. The pathologist reported tuberculosis. Under novocaine anesthesia a disorganized left testicle was removed in the Out-Door Department. 23-x-17. Discharged today in excellent condition. No further data.

For a consideration of this subject at greater length, consult: W. C. Quinby, "Treatment of Genital Tuberculosis in the Male," *Jour. A. M. A.*, 1918, Vol. LXVI, pp. 1790-1795.

#### VESICO-VAGINAL FISTULA.

Woman, No. 6670, aged 50, married, 30-iv-17. Vesico-uretero-vaginal fistula, following hysterectomy before entrance. Left nephrectomy. Plastic on fistula. Easy nephrectomy, normal kidney. Exceedingly hard and unsatisfactory plastic high in vagina made difficult because of scar and absence of cervix on which to make traction. No leakage of urine after operation. No complications. Patient was discharged twenty-one days after operation. 16-vii-18. Patient entirely well since operation. 7-x-9. Patient has had no difficulty with bladder since operation.

### Society Report.

#### PROCEEDINGS OF THE NEW ENGLAND BRANCH OF THE AMERICAN UROLOGICAL ASSOCIATION.

(Continued from page 537.)

#### URETEROVESICAL CYST.

DR. EDWARD L. YOUNG, JR.

Before the days of the free use of the cystoscope in the study of urological cases the presence of a ureterovesical cyst was seldom diagnosed during life. It was seen as a post mortem curiosity, or was found by accident during an intravesical operation directed at some other condition. In recent years, with more frequent use of the cystoscope and greater skill in recognizing what is seen thereby, many cases have been reported, though they are still far from common. In 1896 Blumer could collect but

thirteen cases from the literature, and most of these diagnoses were made on the autopsy table. In 1906, Adrian collected fifty-two cases, of which only twelve were recognized during life.

Ureterovesical cyst, or ureteroceles, is a cystic dilatation of the lower end of the ureter, protruding into the bladder. It may be very small or it may be large enough to cause obstruction to the urinary flow by impinging on the internal meatus, or even, as reported in one case, prolapsing through the female urethra and presenting as a tumor at the external meatus. The shape may vary, though in general it is spherical. The ureter outlet is most often on the summit, but may be at one side of the cyst. It may be of varying degrees of patency, or at the time of observation may be entirely closed. The sac is lined on the outside with bladder mucous membrane and on the inside with ureteral mucosa, with a layer of fibrous tissue between. Some of the reports state that muscle tissue also was present between the two lining membranes. In a few cases stones have been found in the sac. Above the cyst there is always a damaged kidney. If the cyst was the primary damage in the urinary system, the obstruction it causes inevitably results in dilatation of the pelvis and calices, with thinning out of the renal tissue, and, as a rule, when seen there is also an infection present. If the cyst is acquired, the primary pathology may be a ureteral stone which has caused an ulcer just inside the ureter opening before it finally passed out, or an ulcer around the ureteral opening of the bladder mucosa due to any of the various infections common in the bladder.

This condition can occur at any age. It has been found well developed at birth, and a case is reported at sixty-two years of age. From the various accounts it seems to be more common in females than in males; five out of the six cases reported by Caulk were in females. The cysts may be unilateral or occasionally bilateral. From a careful study of his cases, Blumer was convinced that ten out of thirteen were of congenital origin. The occasional association of this condition with other congenital defects has been a strong argument in the minds of a few writers in favor of its congenital origin. Boström and Burchard have advanced the following observation in support of the theory of congenital origin: In certain cases the ureter enters the bladder perpendicularly to its surface without forming a valve of bladder muscle. For this reason the outlet lacks the muscle support ordinarily given, and any obstruction causes it to dilate more readily. Logically this would seem less likely to be the case than the other extreme of implantation, namely, a course so oblique that the last few millimeters run along under bladder mucosa without any muscle over it. In such a case it is easy to see how obstruction would result in

dilatation into the bladder. Causes of obstruction in fetal life from epithelial debris have been frequently demonstrated.

Although it is doubtless true that many cases originate in some slight abnormality of the lower ureter, it seems equally true that many cases do not exist until later in life. Yet even in the latter cases it may well be that the combination of acquired damage and anatomical defect must co-exist before such dilatation can occur. It is well proven that strictures at the ureteral outlet appear after the healing of an ulcer due to tuberculosis or the colon bacillus, or to a previous calculus. The obstruction thus formed acts as the starting-point of trouble. One of the cases reported by Caulk was secondary to a ureterovesical anastomosis.

This condition has no characteristic symptoms, and until there is interference with urination from mechanical obstruction, or infection of bladder or kidney, there is no reason to suspect the presence of a cyst. The only possible exceptions to these are those cases in the past history of which there is note of some frequency and indefinite pain in the side. Inasmuch as these cases, when seen, all have some infection, it is not possible to state whether the previous symptoms were due to the cyst alone or to the already existing infection. As a rule, the symptoms are those of cystitis plus pain referred to a damaged and infected kidney, the symptoms varying with the amount of infection or the degree of damage to the kidney involved. Very rarely the cyst has been large enough to interfere with urination.

Diagnosis should be easy with the cystoscope, as there is no other tumor of the bladder of which I am aware that can give the same picture.

The treatment depends on whether the condition is secondary to some other more important renal condition such as renal tuberculosis, calculus, or pyonephrosis, or whether the obstruction itself is the main cause of the trouble. In the first instance, treatment should, of course, be directed to the kidney, and if, as is generally the case, nephrectomy is necessary, the cyst need not be considered further. If a stone is present in the cyst without gross damage to the kidney above, the stone and cyst can be eliminated by the same act. Where ulceration about a ureter mouth, due either to tuberculosis or the presence of a stone, has once been recognized, it is highly probable that later damage may be avoided by careful watch that the ureteral opening does not become strictured, or, if it does become strictured, by gradual dilatation while it is still possible.

In cases where the cyst itself must be dealt with two methods have been used, one being the suprapubic open operation which through the bladder splits the cyst longitudinally and sutures the opening, or excises the cyst and sutures the edge. Watson and Cunningham,

on the other hand, believe that reimplantation of the ureter into the bladder is the surest method of getting a permanent cure. If the kidney itself has not been sufficiently damaged to demand attention these operations seem needlessly severe, certainly as a first procedure, and some form of intravesical attack ought to be tried. Various surgeons have slit the cyst either through a cystoscope or, in the female, with an instrument carried through the urethra and used at the same time with the cystoscope. The chief objection to this method, however, is that in most cases the edges reunite, and the last condition of the patient is as bad as, if not worse than, the first. Caulk, in a few cases in the female, excised the sac under the guidance of the cystoscope and got a good result. In the following case which I wish to report I used a procedure differing from any of the above mentioned and in which the result was satisfactory, so far as can be told a year and a half after operation.

Mrs. S., 24. Referred for study because of pyelitis of pregnancy.

Past history: So far as she can remember, has always had frequency of urination. Since the age of fourteen has had several attacks of sharp pain in the left flank radiating into the groin, and during the most painful seizures there was an increase of frequency. She has never noticed blood. General condition has been excellent. During the pregnancy, which was her first, there has been more bother with frequency and burning of urination, and a return of the pain in the left groin, the attacks becoming more frequent and more severe. There has been some pain in the right side. Was able to go to a normal delivery without serious trouble.

X-ray showed no evidence of stone, but the outline of a normal sized kidney on the right and less definitely a small kidney on the left. The urine contains macroscopic pus with a growth of colon-like bacilli. Aside from s. p. t. of albumen there was no other abnormality. A total red test showed only slightly diminished function. Cystoscopy easily done, bladder tolerant.

There is in the region of the left ureter a cyst the size of a large plum, which is definitely fluctuant when touched with the catheter. Near the summit is a slightly depressed, elongated area suggestive of a closed ureter mouth, but nothing could be made to break through. From the base of the cyst, diminishing in size toward the summit, are several large blood vessels. Urine from the right kidney contains no pus or organisms. During the cystoscopy there was no evidence that there was any leaking from the cyst, which corresponded to the fact that the examination was made during one of the attacks of pain.

With the scissors through the operating cysto-

scope an incision was made where the apparent ureter mouth was seen. There was an immediate collapse of the cyst and very shortly a lessening of the pain on that side. For about ten days the patient was comfortable; said she felt better than for some time and claimed to be passing more water in twenty-four hours than before. Then for about five days there was a period of lessened amount of urine and beginning pain in the left flank. A cystoscopy done at once in the hope of dilating the strictured opening showed that it was impossible to get a catheter into the cyst even at that time. With the fulgurating machine the whole summit of the cyst was burned until the tissue became white over an area, as nearly as could be told, the size of a five-cent piece. Through the centre of this a hole was then completely burned, again with the collapse of the cyst. The same change in symptoms was noted, and the patient was cystoscoped a week later. The cyst was collapsed. No definite stream could be seen to come from the left side, but there was a steady ooze of cloudy fluid from that side. The ureter could not be catheterized. A month later, during which time the patient had no return of the former symptoms, another attempt at catheterizing the left ureter failed. The patient was then lost sight of.

Sixteen months later the patient reported through her husband that she had remained free from attacks of pain, had had less frequency and felt better than she had for many years; so that it is fair to assume that the opening has not closed again, although there is no cystoscopic evidence.

This case does not help as to etiology, inasmuch as the symptoms are consistent with either a congenital cyst with late infection, or with a primary pyelitis of infancy with later stricture and cyst formation. In either event, her future happiness so far as her urinary tract is concerned, depends on how far damage to that left kidney had been carried.

#### A CASE OF FIBRINURIA.

DR. VINCENT J. O'CONNOR.

Henry L., a Jewish clerk; age, 57 years, entered the Peter Bent Brigham Hospital on September 1 complaining of backache, dull pain under the right costal margin, loss of weight, and "clotting" of the urine. Family history was not important. His habits were good. There was a history of mild fleeting pain in the left flank for seven years. It was non-radiating and not severe enough to worry the patient. He had been obliged to arise once during the night to urinate, for ten years, but there was no frequency of urination during the day. The present illness began in September, 1918, following a mild attack of influenza, which left him with a frequent irritating, non-productive cough. At this time the physician who exam-

ined the urine told him that it was peculiar but did not go into details about the findings. From this time on the patient began to lose weight and had become continually constipated. He would go for several days without a bowel movement, and a resultant abdominal distention and frequent dull discomfort in the epigastrium would be relieved only by vigorous catharsis. In December, 1918, he began to have slight dyspnoea on exertion and more or less general weakness. One month later nocturia increased to three times but there was no frequency during the day and no hematuria, dysuria, or abnormal urine noted.

In April, the patient noted that his urine contained grayish white particles and was somewhat cloudy. He also noticed that the urine became whey-like when standing in a vessel for a few hours. A few weeks after this observation he passed a moderate amount of bright red blood without pain or other associated symptoms. He immediately consulted a physician, who gave him some medicine, and he had no further hematuria at that time.

Early in June the patient began to have a dull "heavy" pain in the right flank and along the right costal margin anteriorly, but this was not severe and caused him no great concern. In the first week in July he consulted a physician because of a slight cough and after a superficial examination was advised to save his urine in twenty-four-hour amounts. He then noted that his single specimens of urine voided into the twenty-four-hour container formed a clear gelatinous layer at times, although there was never a suggestion of blood in the urine. He called this to the attention of the physician who examined the urine and told him he had "too much fat in the urine." Later, at his physician's advice, he underwent a cystoscopic examination and was told that he probably had a stone in the left ureter and that his right-sided pain might be due to the added excretory burden on the right kidney. He continued to lose weight and strength and was unable to work. During this time he was placed upon a fat-free diet and noted no further coagulation of the urine. Two weeks before admission the patient had a severe attack of colicky pain localizing itself in the right groin and over the spine of the pubis on the right. The pain was relieved in three hours, but that night the patient had an attack of hematuria similar to the one in April. In the morning the urine was clear and he has never noted any hematuria since.

A personal communication accompanying the patient stated that he had been suffering from chyluria and that while repeated blood examinations had been made no filarial parasites had been identified. A palpable mass in the right flank was also described. Admission temperature, pulse and respiration were normal. The blood showed 6,400 leucocytes, hemoglobin

per cent. 55, erythrocytes 3,500,000. The differential count was normal, and no malarial, no filarial parasites, nor abnormal red cells were noted. The blood Wassermann was negative.

The urine was acid, specific gravity was 1024, a slight trace of albumin was present and occasional red and white blood cells, but no casts. No fat was noted. Phenolsulphonephthalein test for two hours showed an excretion of 40%.

Physical examination showed marked loss of weight, sallow complexion but no icterus. Heart and lungs were normal. A mass, smooth in outline, firm, and moving on respiration was felt to extend two finger breadths below the right costal margin. No tumor mass could be felt in the right flank, but there was slight costo-vertebral tenderness on deep palpation. The genitalia were normal. There was no varicocele present, and rectal examination showed normal findings. The mass palpated was obviously the liver, although there was no increase in the area of liver dullness above the costal margin. The impression obtained at this time led to the examination of the feces and complete Roentgen ray studies of the gastro-intestinal tract. The findings were normal in every respect.

Cystoscopy revealed a normal bladder but on prolonged observation of the right ureteric orifice a small quantity of old blood clot was seen to come from the ureteral opening. Other than this there was no normal orificial contraction and no efflux noted. The left ureteral orifice was normal, with clear urinary efflux. A No. 6 French catheter passed 30 cm. into the left ureter but a No. 5 French catheter was only with difficulty passed 10 cm. into the right ureter. The urine obtained from the left ureter was normal in every respect. There was no flow obtained from the right ureteral catheter. The phenolsulphonephthalein appeared from the left kidney five minutes after intravenous injection and there was an excretion of 25% of the dye in 15 minutes.

Left pyelo-ureterogram was normal after gravity injection of 20% sodium bromide solution. No gravity flow of the opaque fluid was obtained on the right, so 20 c.c. was injected under moderate pressure. The ureterogram showed a tortuous ureter in its lower third, but none of the fluid reached the renal pelvis.

Following cystoscopy it was noted that the bladder specimen of urine, withdrawn at the time of examination, had partially coagulated in the glass. The coagulum made up half of the volume of the specimen and was a clear, grayish white, transparent, gelatinous mass. The coagulum and urine were carefully studied to determine the nature of this substance. There was no chyle or fat present, no albumose or Bence-Jones protein and no mucin. The jelly gave the characteristic tests for fibrin. These are in brief: Insoluble in water, stiffening of the coagulum on boiling, insoluble in alcohol, insoluble in neutral solutions, increase in



swelling of coagulum on addition of weak acids or alkalies, gradual dissolution in concentrated mineral acid and subsequent reaction as acid albumin. An occasional leucocyte and erythrocyte were found in the centrifuged specimen.

Urine examination on the three following days showed the presence of fibrin masses and shreds in the urine, but no further spontaneous coagulation of the urine occurred after voiding.

Physical examination now made apparent an indefinite palpable mass in the right flank overshadowed anteriorly by the position of the liver. A diagnosis of neoplasm of the right kidney was made.

Operation was performed on September eleventh under nitrous oxide and oxygen anesthesia. A right lumbar incision was made and a very large nodular right kidney was adherent to the surrounding structures. The tumor mass was removed with some difficulty because of its size and the perirenal fat was removed without incision. The peritoneum was opened posteriorly and the liver found to be normal in size, consistency and position. The wound was closed without drainage and the patient made an uneventful recovery, being up and about in a wheel chair on the tenth day.

The urine, on repeated examinations, after operation, was normal. The phthalein excretion before discharge was 35% in two hours. The patient was discharged on October 11, in good condition, having gained eight pounds since operation.

Pathological report of Dr. S. B. Wolbach:

Gross description: Specimen consists of a right kidney tumor weighing 926 gms. and measuring 12 cm. from pole to pole and 10 cm. from the pelvis outward in the median section. In thickness the measurement is 10 cm., not including a thick layer of perirenal fat, which is very adherent to the surface of the tumor mass. The external surface is smooth, but most of the surface presents rounded, irregular nodules, red in color, with the exception of one that is quite firm upon palpation and white in color. Sectioning through the median line in the mass, the surface upon rough inspection presents no normal kidney structure or substance, the whole kidney being apparently replaced by lobules of spongy and firm tumor cells. On close inspection, however, at both lower and upper poles, there is still a very thin shell of cortex measuring not over 2 mm., which shows definite glomeruli. This small amount of renal tissue extends for only 2-3 mm. along the edge, when it disappears, becoming a mere layer of fibrous tissue which surrounds and apparently bounds the growing tumor cells. The pelvis of the kidney is filled with a mass of fat and nodular tissue which is about 8 cm. long and 2 cm. thick, and in its center there is a small, hard, apparently calcareous mass or nucleus. The entire mass seems to be attached to one side of the pelvis where the lining mem-

brane of the pelvis ends. This membrane is for the most part soft, smooth, and glistening, but there are seen to be small implantation areas of cells. The cut surface of the kidney shows a large, firm, white area about centrally located, measuring 4x5 cm. This area stands out in contrast to the rest of the areas of tumor cells because of its white color and firm structure. The other portions of the tumor, which are definitely localized, separated, and surrounded by white fibrous tissue bands, are red in color, of spongy consistency and have a more medullary and glandular appearance. Tissue from the tumor was fixed in Zenker and a frozen section presents the picture of medullary carcinoma.

Microscopic report: There are sections from four different portions of the tumor stained with eosin, methylene blue, phosphotungstic acid, hematoxylin. The sections present widely different appearances according to the portion of the tumor from which they came. Three of the sections present a somewhat adenomatous structure and are built up of tubules and small cysts with papillary ingrowths lined by columnar cells, most of which are of vesicular outline, due to a marked vacuolization. This portion of the tumor is divided up into larger and smaller nodules by a fairly heavy framework of connective tissue and in some places bands of smooth muscle, the latter possibly derived from the kidney structure (pelvis). The cells forming tubules are supported by a very delicate connective tissue abundantly supplied with capillaries and suggest the renal origin of the tumor. Section stained for fat after fixation in Klotz fixative showed a very slight amount of fat or rather lipid material, as the color of an occasional granule is pale orange. This portion of the tumor contains small areas of hemorrhage, both recent and ancient. The other portion of the tumor corresponding to the dense, white nodule, noted in the gross, presents a complex appearance. In one portion it is definitely invading the capsule and has the structure of carcinoma with abundant stroma. Other portions present solid masses of rather vesicular epithelial cells with slight tendency toward alveolar formation. The bulk of this portion, however, is composed of spindle-shaped cells accompanied by a small amount of diffusely distributed intercellular substance which stains a feeble yellow with phosphotungstic acid stain and on the whole presenting the appearance of a sarcoma rather than a carcinoma. There seems, however, to be a retransition from the adenocarcinomatous appearance to this structureless portion. The cells of both portions have some features in common, namely, somewhat vesicular appearance and in the size and chromatin content of the nuclei. It is also worthy of note that these sarcoma-like areas contain considerable dark brown granular pigment enclosed within phagocytic cells and



my interpretation is that in these sarcoma-like portions we have a simultaneous growth of tumor in fibroblasts in the organization of areas of hemorrhage. Mitotic figures are abundant in all parts of the tumor, particularly abundant in the last described portion.

Comment: Tumor is an adenocarcinoma of renal origin and has in places taken on the characteristics of a more malignant form of carcinoma with a loss of gland-like structures.

Diagnosis: Carcinoma of kidney.

There are two very interesting features about this case, (1) a rather unusual type of renal tumor, (2) the very rare finding of fibrinuria.

Any study of the comparative frequency of the different types of malignant disease of the kidney recorded previous to about 1900 is not only confusing, but apparently impossible. Well authenticated cases of renal carcinoma are so few that it is practically impossible to give any definite data in regard to their etiology.

Morris classes 41 out of 154 renal tumors as carcinoma. Albarran and Imbert, and Tuffier and Brechet state that epitheliomata constitute nearly the entire number of malignant tumors of the kidney in the adult. Roberts reports 67 cases of carcinoma of the kidney, seven of which were bilateral, and Guillet reports 72 cases, seven of which were bilateral. Kelynaek reports 37 instances of carcinoma of the kidney, in two of which the involvement was bilateral.

In the light of our present day knowledge of renal pathology these statistics are worthless, as no clear differentiation of hypernephromata from other malignant renal neoplasms is made.

Garceau, in 1909, found three instances of carcinoma of the kidney in a study of 42 renal tumors occurring at the Massachusetts General Hospital and the Boston City Hospital. Binney recently reports seven cases of carcinoma in 114 reported instances of renal neoplasm.

Spontaneous coagulation occurs very exceptionally in the urine without an admixture of blood. If coagulation of the urine occurs spontaneously, when the urine is allowed to stand, the presence of fibrinogen is always indicated.

Fibrinogenuria is responsible for the clotting of the urine in cases of chyluria due to infection with the *Filaria sanguinis hominis* and is rather frequently associated with this condition. It is not necessary to discuss this fact in the case just reported. There are twenty reported cases of fibrinuria in the literature.

In seventeen instances fibrin coagula were formed repeatedly in the urinary tract before the urine was voided, and there was no subsequent coagulation of the urine after voiding. In three cases the urine when passed contained fibrin coagula and the urine also coagulated on various occasions after voiding.

In the reports concerning the above cases reference is made to six other cases of fibrinuria not specifically reported in the literature.

In passing, I would like to point out briefly the types of conditions in which fibrinuria has occurred.

Senator, in 1874, makes the first case report in which fibrin coagula appeared in the urine. A woman suffering from acute articular rheumatism was being treated by applying cantharides plasters over several joints. The resultant symptoms were those of an acute toxic nephritis with spontaneous coagulation of the urine. Complete disappearance of all urinary symptoms immediately followed the discontinuance of the cantharides applications.

Baumüller reports fibrinuria in a case which he diagnosed as chronic catarrhal pyelitis. He also reports a personal communication from Koch in which the latter observed fibrinuria in a case of carcinoma of the kidney verified at autopsy.

Von Jaksch reports two cases, one a perinephritic abscess which recovered without treatment and the other a chronic urinary infection which he diagnoses as a ureteritis membranacea. Klein followed a case of fibrinuria for over four years and at autopsy found a granular nephritis present.

Rothschild reports an instance of sarcoma of the right kidney in which spontaneous coagulation of the urine occurred. Nephrectomy was done successfully and the urine was normal during the p. o. observation.

Mosse, Frank, Gossner, Vogel, Bouchard, and Greig report instances of repeated fibrinuria in what they term catarrhal pyelitis or cystitis.

Furbringer mentions the occurrence of fibrinuria in two cases of nephritis in typhoid fever, both of which recovered from the disease, the urine on repeated subsequent examinations being normal.

Israel in his textbook mentions the occurrence of fibrinuria in a case of neoplasm of the kidney, and Suter states that fibrinuria is a very rare but important symptom in carcinomatous involvement of the urinary bladder. He, however, cites no cases in which this occurred.

Emerson noted spontaneous coagulation of the urine in a case of chronic parenchymatous nephritis four hours before death.

That the fibrin coagula identified in these various types of disease of the urinary tract were chemically and microscopically identical seems evident from the case reports. In the majority of cases the clotting occurred before voiding and coagula were formed in the bladder, ureter, or renal pelvis. In the rarer cases, such as the one I have reported here, the clotting may occur at once after voiding or the coagulum may not be completely thrown down for several hours. The rapidity with which the clotting occurs depends upon the amount of fibrin ferment and lime salts present in the urine. Several early authors have insisted that an alkaline urine is necessary for the coagula-

tion, but both laboratory and clinical evidence shows that either alkaline or acid urine can hold fibrin in solution for a time.

That the fibrin found in the urine in this case was not a product of the carcinoma itself but a result of the associated renal destruction seems evident from a study in these cases. That the small area or remaining renal tissue not involved in the carcinoma should be permeable to such large quantities of fibrin ferment and so few blood cells is an interesting and apparently very rare phenomenon.

DR. TENNEY: I have here a specimen, which was spoken of at the last meeting, a glass thermometer that was taken from a bladder and which had a collection of lime salts around it. It had been in there five months. I don't know why it was put in her bladder. The patient was suffering pain and discomfort and her doctor discovered this thermometer in her urethra and pulled it out.

I took out this large, ureteral calculus last spring, which was close to the bladder, and an interesting thing is that a few weeks ago the man returned complaining of obstruction at the same point where the calculus had been removed. I did not think this occurred so soon where ureteral calculus had been taken out.

DR. QUINBY: How long since it was removed?

DR. TENNEY: As nearly as I can recall, five months. The history of the case was obstruction for 30 years before the calculus was taken out.

(To be continued.)

### Book Review.

*Radio-Diagnosis of Pleuropulmonary Affections.* By F. BARJON. Translated by JAMES A. HONEIJ, M.D., Yale University Press, Publishers. May, 1918.

Dr. Honeij is to be congratulated upon his excellent translation of Barjon's work on the x-ray, and the medical profession of this country, at least that part of it which deals with diseases of the lungs, is likewise similarly to be congratulated upon having such excellent work at its disposal. Not only is the print clear and legible, the book itself of a convenient size and weight, and the photographs of the highest order of excellence, but there is also running through it a vein of conservatism and modesty which is exceedingly rare in the majority of x-ray treatises.

It would appear to the reviewer at least, that many x-ray enthusiasts would do away or endeavor to do away with the clinician or clinical

methods. The tone of this book is, however, quite different, as shown by the following, on page 117: "It is not to be assumed that the radiological diagnosis of tuberculosis is to displace clinical examination and auscultation. Radiological examination may often be useful, but may often give no indication. It is not infallible. Certain light, disseminated lesions, insufficient to change the density or the elasticity of the parenchyma may perfectly well pass unnoticed. The radiologist, when not taking into account clinical methods of examination, may very well declare a case of incipient tuberculosis with apparent signs of auscultation to be non-tuberculous. But the same is true of the physician who has relied wholly on clinical methods."

That the author is a firm believer in the value of the x-ray, however, is shown in many ways; for instance, "The time is coming when the information furnished by radiological examination will be as indispensable as that obtained by means of the stethoscope," and . . . . . (page xvii) "At once the superiority of this method supersedes all others, for palpation and auscultation give information only as to the condition of those organs which are close to the thoracic wall; auscultation reveals only lesions superficial enough to transmit to the ear perceptible sounds, while the eye can observe lesions that are concealed in the deeper tissues."

In the initial chapter, methods of examination of the normal chest are considered. He then takes up the subject of pleurisy and circumscribed and encysted pleurisy. He frankly admits that in many pleuritic processes, radiography is of comparatively little value. As an adjunct to the use of artificial pneumothorax, however, x-ray examination both before and during treatment is indispensable. He urges that radiologists learn to discuss the interpretation of abnormal shadows of the hilus region, which might almost be called the area of romance in the chest.

In his chapter on the enlargement of the tracheobronchial gland, he admits that in adults such enlargement is often due to perfectly innocent infection. In children, however, he believes that tuberculosis is the most common cause. His chapter on the acute infectious pulmonary processes, particularly abscesses and gangrene, is of great value. In tuberculosis of the lungs, he believes that not only is an x-ray examination of value in diagnosis, but that it is also important in following the progress of the individual patient. He admits, however, that in real incipient tuberculosis, clinical examination, history and auscultation signs and symptoms are of more importance than the x-ray.

On the whole, this book is an excellent one and a valuable contribution to our literature on this subject.

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BOSTON MEDICAL AND SURGICAL JOURNAL

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### SHORTAGE OF PHYSICIANS.

THERE is a serious shortage of physicians in the United States and from the number of students in the medical colleges it is apparent that the conditions will grow worse rather than better during the next few years. At the same time the number of quacks is on the increase. Such being the case, it seems that the leaders of medical education should take an inventory and determine, if possible, just what is the cause of the reluctance of young men to enter the profession.

The following story, which is told by a surgeon of note, will illustrate one phase of the question. It appears that his son entered Johns Hopkins some three years ago. At the same time a classmate of the boy went to Baltimore and entered a business house. Now, at the end of three years the first boy finds that he has at least four years before he can begin at the bottom of the ladder, while his friend holds an

important position and commands a salary which a physician can attain only after years of hard work. The student recently wrote to his father, "I have a mind to chuck the whole thing. I can sell automobiles as well as he can."

There is no doubt but that a man who has had a premedical training followed by a college course and an internship is better qualified for the practice of medicine than he who enters the medical college at the completion of his high school course, but it is also true that many of the brightest men do not wish to spend seven or eight years in preparation, and there are many very deserving students who would make excellent practitioners who cannot afford to spend seven or eight years in unproductiveness. These men we lose and their places remain vacant.

Would it not be possible to rearrange the course of study so as to give the student the essentials of his premedical education without taking so much time and money?

Looking beyond the confines of the college and medical school, we find that the practitioners of medicine are roughly divided into progressive and unprogressive; that this division does not depend upon their previous education; that the incomes of the several men are not so much dependent upon their professional skill as upon their business ability. Snap diagnoses, slovenly treatment, and failure to use modern methods in diagnosis and treatment are driving patients from office to office until they arrive at some quack's who has sufficient knowledge of psychology to fool the sufferer.

What we need to overcome this is a limited term for the license that can be renewed only after demonstration that the applicant has kept abreast of the recent developments of medicine. This is a perfectly practical proposition once the majority of the profession realize the importance. As is well known, there was a time when the only attempt at maintenance of a high standard of medical proficiency was made by the Army and the Navy. The standard on entrance was very good but it was learned that after a man passed his second examination many of them progressed no further. To overcome this, about the time state examinations began, laws were enacted which ultimately required that every member of the medical

corps, up to and including the lieutenant-colonels, must demonstrate their professional ability before being promoted. The result is that in the medical corps of the Army and the Navy you will find a body of men well read in their profession and alive to modern methods.

Let us strive for a shortened course without lowering the standard and a plan whereby after graduation the practitioner will have to keep up in the branch of medicine he is following.

J. W. BREWER.

#### MEMBERSHIP IN MEDICAL SOCIETIES.

LAST spring, at a meeting in the City of New York, where a medico-social subject was under discussion, the representatives of the medical profession opposed certain provisions of the proposed legislation. An attorney of the other side asked the speaker what he represented and on being answered, "The medical profession of the state," the retort was that the organized medical profession represents barely one-half of the practicing physicians and therefore the speaker did not represent the profession.

According to the *Journal of the American Medical Association* of May 1, 1920, there are 145,384 practicing physicians in the United States; of these, 83,338, or 57%, belong to the societies of the several states, while the fellows of the American Medical Association amount to 45,266, or 31% of the total number of practicing physicians.

From the same source we find that there are 10,805 physicians in New England; 64.2% belong to the state societies and 36.6% are fellows of the American Medical Association.

As long as such conditions exist it is manifest that the medical profession at large can have but little effect upon legislation even though that legislation vitally affects its members. Divided, we can accomplish nothing; but united, we should be able to exercise a proper supervision over legislation that affects us or the public injuriously.

If the American Medical Association is to represent the profession in this country it should aim to get as near 100% membership as possible. This can be done, but it may re-

quire some modification of methods and government. At this time, when all kinds of unwise legislation are being proposed, there is need for a strong association.

Let every county aim to have a hundred per cent. membership before the year is up.

#### REVIVAL OF HOUSEHOLD INDUSTRIES AND DOMESTIC ARTS FOR RECONSTRUCTION PURPOSES.

THE Society for the Revival of Household Industries and Domestic Arts has found hand spinning, weaving, quilting, and other industries of former days to be of real value in reconstruction work. Wounded soldiers and sailors find the work interesting and not too difficult, and encouraging in the fact that all they can produce is easily sold at good prices. It is the intention of the Society to introduce this work also in state hospitals for the feeble-minded, almshouses, asylums, reformatories, and other institutions where the inmates are in need of some light, interesting, and lucrative employment. The hand-made articles of our forefathers never were prized more highly than they are today. In order to extend the work among wounded soldiers and others who may find it helpful, the Society needs additional spinning wheels, reels, heckles, cards, and any other of the old tools which may be stored in our attics and of no value beyond some slight sentimental attachment. These articles could be put to useful service. Teachers are also needed to learn the arts of spinning and weaving, quilting, candle making, tatting, hand-wrought iron work, and other similar industries. Any persons who are desirous of aiding this work among our soldiers may communicate with the Secretary of the Society for the Revival of Household Industries and Domestic Arts, 53 East 44th Street, New York.

#### ADOPTION OF MEASURES TO INSURE THE REPORTING OF COMMUNICABLE DISEASE.

ALTHOUGH the majority of practising physicians promptly report in most instances the cases of disease dangerous to public health which come to their attention, there still remain

a number of physicians who fail conspicuously in fulfilling their obligations in this respect. The futility of endeavoring to control outbreaks of communicable diseases without knowing the infecting source is apparent. In order that the health of the Commonwealth may be preserved by the reporting of dangerous diseases to local boards of health, it has been deemed necessary for the Division of Registration in Medicines of the Department of Civil Service and Registration and the Department of Public Health so to coöperate that compliance with this regulation may be insured. To this end, it has been decided that the names of physicians who do not report cases of diseases dangerous to the public health to their local boards of health shall be furnished to the Department of Public Health. The Department of Public Health will present to the Division of Registration in Medicine of the Department of Civil Service and Registration these names with the proper evidence of neglect to report such diseases. Where it is known positively that the physicians persistently neglect and refuse to report such diseases, a hearing will be granted to the offending physician, giving him the opportunity to show why his license to practise medicine should not be suspended. The protection of the health of the community and of the State demands this action, although it is not to the credit of the profession that such drastic procedure should be necessary.

#### MEDICAL NOTES.

**STUDY OF BOTULISM IN CALIFORNIA.**—An intensive study of botulism is to be undertaken in California by means of funds raised for this purpose by the olive growers and members of the canning industry. The investigation will be conducted in the laboratories of the Stanford University Medical School and the George William Hooper Foundation for Medical Research of the University of California. The United States Health Service and the California State Board of Health will coöperate in this research, which will include a study of the distribution of the *Bacillus botulinus* in nature, of the ways in which food materials may become infected, and of the steps necessary to destroy the organism when it has infected raw food materials. It is expected that the investigation will cover a period of at least two years.

**ITALIAN JOURNAL OF HEMATOLOGY AND SEROLOGY.**—There has been issued recently the first number of *Hematologica*, an Italian journal of hematology and serology, edited by Dr. Ferrata of Naples and Dr. Moreschi of Sassari. It is the purpose of this journal to publish original works in the French, English, and Italian languages. The colored illustrations of the first number, which are furnished to authors without expense, are remarkably good. *Hematologica* deserves the encouragement and collaboration of the American profession.

**AMERICAN MEDICAL EDITORS' ASSOCIATION.**—The following program was presented at the fifty-first annual meeting of the American Editors' Association held at New Orleans, Louisiana, on April 26 and 27, 1920:

Address of Welcome: Dr. Isadore Dyer, *New Orleans Medical and Surgical Journal*, New Orleans, La.

President's Address: "The Nation's Greatest Need: A National Department of Health," Dr. Seale Harris, *Southern Medical Journal*, Birmingham, Ala.

"The State Journal," Dr. Holman Taylor, *Texas State Medical Journal*, Fort Worth, Texas.

"Medical Journalism: Pedagogy or Advertising," Dr. Sarah Hobson, *Journal of American Institute of Homocopathy*, Chicago, Ill.

"Practical Suggestions in the Management of Medical Journals," Mr. S. Dewitt Clough, *American Journal of Clinical Medicine*, Chicago, Ill.

"Medical Journals and Medical Quackery," Dr. Oscar Dowling, President, Louisiana State Board of Health, New Orleans, La.

"The Relation of Medical Journals to the Lay Press," Dr. A. T. McCormack, *Kentucky Medical Journal*, Louisville, Ky.

"Health Insurance and the Public," Dr. Frederick L. Hoffman, Prudential Insurance Company, Newark, N. J.

"The Place of Cardiology in Current Medical Literature," Louis F. Bishop, *American Journal of Gastro-Enterology*, New York, N. Y.

"Medical Life Insurance as a Specialty, and Medical Journal Work in Connection Therewith," Dr. M. M. Smith, Medical Insurance and Health Conservation, Dallas, Texas.

"Medical Journals and Child Hygiene," Dr. Richard A. Bolt, General Director, American Child Hygiene Association, Baltimore, Md.

"Medical Journals and the Campaign against Cancer," Mr. F. J. Osborne, Executive Secretary, American Society for the Control of Cancer, New York.

"Medical Journals and the Problems in Social Hygiene," Dr. Alec N. Thompson, Director, Medical Department, American Social Hygiene Association, New York, N. Y.

"Report of Committee on Necrology," Dr. C. W. Fassett, *Medical Herald*, Kansas City, Mo.

"Report on Patents and Trademarks," Dr. F. E. Stewart, *Practical Druggist*, Philadelphia, Pa.

"Plans for Developing the Medical Department of the Army," Dr. Merritte W. Ireland, Surgeon-General, U. S. Army, Washington, D. C.

"The Public Health Service," Dr. Hugh S. Cumming, Surgeon-General, U. S. Public Health Service, Washington, D. C.

"The Dissemination of Medical Information to the Medical Corps of the Navy," Dr. J. S. Taylor, Capt.



Medical Corps, U. S. Navy, Editor, *Naval Bulletin*, Washington, D. C.

"The Internist's Debt to Current Medical Literature:" Dr. Lewellys F. Barker, Baltimore, Md.

"Surgery's Debt to Medical Journals:" Dr. George W. Crile, Cleveland, Ohio.

"Medical Journals and Tropical Diseases:" Dr. Sidney K. Simon, Secretary, American Society of Tropical Medicine, New Orleans, La.

"The National Anesthesia Research Society:" Dr. F. H. McMechan, Secretary, American Association of Anesthetists, Avon Lake, Ohio.

"Medical Abstracts:" Dr. George A. Wilson, Editor, Abstract Department, Tice's Practice of Medicine, New York, N. Y. To be read by Dr. Frank Smithies.

"Medical Abstracts:" Dr. R. H. Sayre, *New York Medical Journal*, New York, N. Y.

"Editorial Writing:" Dr. H. Edwin Lewis, *American Medicine*, New York, N. Y.

"The Elevation of Literary Standards in Medical Journals:" Dr. H. S. Baketel, *Medical Times*, New York, N. Y.

"Medical Journals and Medical Education:" Dr. Charles Cross, *Pacific Medical Journal*, San Francisco, Calif.

"Advertising Ethics:" Dr. A. L. Benedict, *Buffalo Medical Journal*, Buffalo, N. Y.

**MEDICAL SERVICE IN A WISCONSIN TOWNSHIP.**—The following interesting account of an experiment proposed by the officials of a township in a county located in the extreme northwestern part of Wisconsin in order to make possible competent medical service to the community has been published in the *Public Health Report* for April 16, 1920:

"It is planned to levy a sufficient tax to provide an annual retainer of \$1,000 for a physician who shall practice medicine and surgery in this locality. Furthermore, it is proposed to bond the township sufficiently to provide funds for the erection of a physician's residence, the cost of which shall not exceed \$5,000. The physician will be permitted to reside in this dwelling and also to have his office therein without the payment of rent. A suitable garage and barn will also be provided.

"In return for the annual salary of \$1,000 and the rent-free residence, office, garage, and barn, the township board reserves the right to prescribe the fees which shall be collected by the physician. Tentatively the charge of \$2.00 per call made within the township boundaries, together with mileage at the rate of 50 cents per mile traveled, has been set as the fee the physician shall collect. When a call is made outside the township the charge shall be \$3.00, with the same mileage charge. However, \$1.00 of each \$3.00 fee so charged shall revert to the township treasury. Charges for confinements, operations, and other unusual attendance are to be made in accordance with the county medical society's fee schedule.

"It is the intention of the officials in charge of the project to have the physician act as health officer and serve as medical attendant to the indigent supported by the township. He is also to serve as school physician, making a

physical examination of the pupils at least once in three months during the school term. Furthermore, he is to advise the members of the board of health in professional matters."

The practical operation of this plan will be of interest to physicians and rural communities throughout the country.

**BOTULISM IN OREGON.**—Botulism has been made a reportable disease in Oregon. The attention of local health officers and physicians of the State has been called to the importance of the disease, and they have been asked to state with reports the probable causative food factors. The most conspicuous symptoms of botulism have been described as diplopia, aphonia, ptosis, progressive muscular weakness or tremors with no temperature.

#### BOSTON AND MASSACHUSETTS.

**THE FREE HOSPITAL FOR WOMEN.**—The Free Hospital for Women in Brookline was organized in 1875 for the purpose of furnishing to women without means free surgical aid and treatment of diseases peculiar to their sex, and treatment in similar cases, without profit to the corporation, to women financially able to pay for the service of the hospital. The forty-fourth annual report contains statistics for the year ending October 1, 1919.

There were admitted to the hospital 925 patients, of whom 613 were operated upon. These figures show a decrease over the preceding year, due to the fact that for two months the hospital was devoted entirely to the treatment of influenza and measles. Fifty-eight influenza patients were cared for. There were performed 1,739 surgical operations, which are listed in the report. Of the patients discharged, 535 were cured, 92 relieved, 277 diagnosed, and 1 unrelieved. There were 19 deaths, 9 of which were due to influenza. The Out-Patient Department conducted 5,539 consultations; there were 1,566 new patients. It was necessary to close this department for three weeks on account of the influenza. The Pathological Laboratory examined 1,563 slides and 1,853 specimens, and made 1,557 urinary and 74 bacteriological reports.

During the time of the war, the post-graduate course given by the Training School was shortened to three months; this proved to be, on the whole, unsatisfactory, and the present



class will receive training for six months. Diplomas were given to thirteen nurses for the completion of a three months' practical course, and five nurses received diplomas for the regular six months' course.

**APPOINTMENT OF DR. STANLEY H. OSBORN.**—Dr. Stanley H. Osborn of Cambridge has been appointed Director, Bureau of Preventable Diseases, of the Connecticut State Department of Health. Dr. Osborn served with the American Red Cross in the Balkans in 1915, combating typhus fever and malaria. In 1915, he joined the Massachusetts Department of Health as a district health officer and in 1917 was appointed epidemiologist, which position he has held up to the present time, with the exception of fourteen months' service overseas in the medical corps of the army during the war.

**CONFERENCE OF THE MASSACHUSETTS TUBERCULOSIS LEAGUE.**—The sixth annual meeting and conference of the Massachusetts Tuberculosis League was held in Boston on May 6, 1920. Dr. Edward O. Otis, president of the League, delivered the opening address. Dr. Ernest D. Easton, executive secretary of the New Jersey Tuberculosis League, addressed the meeting on "The County As the Unit of Organization for Tuberculosis Work," which was followed by general discussion. Under the general subject of "Case Finding Work" were the following addresses: "Through the State District Nursing Association," by Miss Celia A. Lemner; "Through the City Dispensary," by Dr. Sumner H. Remick; "Through Consultant Service," by Dr. Harry S. Wagner. Discussion of these topics was led by Dr. P. Challis Bartlett and Dr. William J. Gallivan. The subject, "How to put Through a Successful Seal Campaign," was considered by Dr. Robert B. Kerr and discussed by members of the League. Reports from local associations were read on the work accomplished during the past year, and plans and suggestions for the future were considered.

**FAULKNER HOSPITAL TRAINING SCHOOL GRADUATING EXERCISES.**—The graduating exercises of the Training School of the Faulkner Hospital in Jamaica Plain were held on the evening of May 6, 1920. The class of 1920 included 13 nurses.

#### NEW ENGLAND NOTES.

**THE BUTLER HOSPITAL, PROVIDENCE, R. I.**—The annual report of the Butler Hospital, Providence, R. I., for the year 1919, was presented to the Corporation at its sixty-seventh annual meeting. The report is one of exceptional interest, inasmuch as it outlines briefly the development of hospital care for nervous and mental diseases since the year 1868. It is only during comparatively recent years that the subject of prevention of nervous diseases has received any adequate attention. The original purpose of hospitals for the insane was to provide shelter and comfort for those committed to their care. As hospitals have become more numerous, there have been made efforts to investigate the underlying causes of mental disease. In 1868, a pathologist was appointed temporarily by the Utica State Hospital; up to that time the causes of deviations from normal conduct had been enshrouded in mystery. The pathological department of the Utica State Hospital, however, proposed to study bodily secretions and excretions, the state of the pulse as revealed by the sphygmograph, the effect of remedies upon the pulse, the condition of the cerebral vessels as revealed by the ophthalmoscope, the condition of the skin, the morbid conditions developed at autopsy, and to portray them by photographs and photomicrography. This work was carried on intermittently until 1886, when it was practically discontinued. The beginning made by Utica was of great value, however, to other hospitals in the country, as it had emphasized the need of more specialized efforts in that direction. It was the pioneer enterprise in a new field and the forerunner of similar departments in other states.

A few years later, the New York State Pathological Institute and the McLean Hospital began to conduct investigations of mental diseases. The examples set by these institutions was followed by others, including the Butler Hospital. In the report for 1919, interesting histories are cited of cases treated in the early forties, when the Butler Hospital began its career; at that time hospitals were concerned more with the custody of the person than with the treatment of the disease. In contrast to these early case records, a modern case history is quoted to show the very different hospital procedure of today.

The annual report contains the following statistics:

There were in the Butler Hospital on Dec. 31, 1918, one hundred and thirty patients, fifty-eight men and seventy-two women. There have been admitted one hundred and thirty-six patients, sixty-six men and seventy women. The whole number under treatment during the year was two hundred and sixty-six, one hundred and twenty-four men and one hundred and forty-two women. The maximum number at any one time was one hundred and forty, the minimum was one hundred and twenty-five, and the average weekly number for the year one hundred and thirty and eight-tenths. The discharges numbered one hundred and thirty-two, fifty-five men and seventy-seven women, leaving in the hospital at the end of the year one hundred and thirty-four patients, sixty-nine men and sixty-five women.

Of the admissions seventy-three were residents of Providence, thirty-eight of other parts of Rhode Island, nineteen of other New England States (namely, fourteen from Massachusetts, three from Connecticut, and two from New Hampshire), and six of other states (namely, one from Illinois, one from Maryland, one from New Jersey, and three from New York State).

Of the discharges, one patient was unchanged, twenty had recovered, fifty-five were improved, thirty were unimproved, and twenty-six had died. The causes of death in these cases were as follows: Cerebral embolism, five; broncho-pneumonia, five; cardiovascular degeneration, five; cerebral hemorrhage, four; general paresis, two; carcinoma, one; rheumatic chorea, endocarditis, one; chronic myocarditis, chronic nephritis, one; acute parenchymatous nephritis, one; diabetes mellitus, one. Of the admissions forty-two and two-tenths per cent. were on voluntary application. Among the admissions were fourteen former soldiers and sailors committed to the care of the hospital by the Public Health Service.

Twelve nurses were graduated from the Nurses' Training School in 1919.

NEW ENGLAND WAR RELIEF FUNDS.—The principal New England war relief funds have announced the following contributions:

French Orphanage Fund	.....\$586,317.35
American Fund for French	
Wounded (for the American	
Hospital at Rheims)	..... 357,784.13
Italian Relief Fund	..... 326,978.90
American Committee for Devas-	
tated France	..... 200,857.54

## Obituaries.

### ELMER ERNEST SOUTHARD, M.D.

IN the death of Dr. Elmer Ernest Southard the medical profession has suffered the loss of one of its most brilliant and promising personalities. His short life was one of splendid achievement, devoted to scientific progress and the service of humanity. Dr. Southard was born in Boston on July 28, 1876, the son of Martin and Olive Wentworth (Knowles) Southard. He was graduated from Harvard University in 1897, receiving his medical degree in 1901. After leaving Harvard, he attended the Senckenberg Institute at Frankfurt and the University of Heidelberg. In 1917 he received the degree of Sc.D. from the George Washington University. In 1906 he married Dr. Mabel Fletcher Austin of Boston.

Dr. Southard served at the Boston City Hospital as interne and assistant in pathology from 1901-1903, as assistant visiting pathologist in 1904-5, he became instructor of neuropathology at the Harvard Medical School in 1904-5, assistant professor from 1906-1909, and had been Bullard professor since 1909. He entered the Massachusetts state service on January 1, 1906, as assistant physician and pathologist of the Danvers State Hospital; he was made pathologist to the State Board of Insanity on May 1, 1909, Director of the Psychopathic Department of the Boston State Hospital in 1912, and Director of the Massachusetts Psychiatric Institute in 1919. He became Director of the Eugenics Record Office, Cold Springs Harbor, New York, and a member of the board of scientific directors of the Bedford Hills Laboratory, Bureau of Social Hygiene, New York. Dr. Southard served as assistant editor of the *Journal of Nervous and Mental Diseases*, the *Psychiatric Bulletin*, and the *Journal of Clinical and Laboratory Medicine*. He was a member of the American Academy of Arts and Sciences, the Association of American Physicians, the American Medical Association, the Massachusetts Medical Society, the American Medico-Psychological Association, the American Psychopathological Association, the New England Psychiatric Society, the Boston Society of Psychiatry and Neurology, the National Epilepsy Association, and the American Genetic Association. Dr. Southard contributed many valuable articles to medical sci-

ence, and collaborated in the publication of two volumes, *Neurosyphilis*, in 1917, and *Shell-shock and Neuropsychiatry*, in 1919.

In appreciation of his life and achievement, Dr. Richard C. Cabot has written, in part:

"The state of Massachusetts and Harvard University may both be proud of their share in the career of Dr. Elmer E. Southard; the university, because it first revealed him to himself and linked him with two great personalities whose ideals governed the rest of his life; the State, because it was wise enough and liberal enough to recognize and use his brilliant, fearless and uncompromising spirit during the years 1906 to 1920.

"Unable through boyhood to join in the ordinary sports and interests of his contemporaries because of his physical limitations, he thought of himself as a failure, until he reached college. There he discovered, for the first time, that he could accomplish something by means of his profound and penetrating mind, which hitherto had availed him but little. At Harvard, he came under the influence of Professor Josiah Royce and Professor William James, each of whom fired his enthusiasm and shaped his future activities.

"Out of the study of the brains of the feeble-minded, Dr. Southard determined to win better knowledge of the human mind in its highest workings. This was his central interest. 'To utilize the psychopathic by-products of society to its betterment' was his own way of stating it. He believed that out of the study of families containing one mentally abnormal member important help could be gained for the better practice of normal family life. The deepest meaning and secrets of the spiritual life were the centre of his interest; but he hoped to find these through the study of the abnormal.

"Minute microscopic study of the brain occupied his early professional years and led to important discoveries as to the nature of cerebral disease. But with the opening of the Boston Psychopathic Hospital under his directorship, in 1912, he began the study of living minds, not only of the insane but of the law breakers, alcoholics, cranks, tramps, drug habitues, difficult children and other peculiar types brought to the Out-Patient department of that institution by social workers, court officials and friends.

"Through the study of this extraordinary group of sufferers Dr. Southard was led to a deeper and broader idea of what the work of a psychiatrist should be. For in this work he found himself forced to study not merely the defective or abnormal mind, but bodily diseases, the effects of alcohol and morphine, the results of poverty, ignorance, bad teaching and bad environment, and the misfortunes produced by becoming entangled in the meshes of the law.

The neuro-psychiatrist fit to understand this huge welter of human misfortune must study and seek to understand his patient from every point of view, mind, body and estate, the influences of home and school as well as those of disease.

"Returning of late years to his root idea of 'utilizing the psychopathic by-products of society to its betterment,' he became enthusiastically interested in the movement for better mental hygiene, which meant for him a reform of education and of morals, a radical regeneration of the human spirit from the point of view of the lessons learned from mental disease. In this new hope he attacked the problems of industry, and with a grant from the Engineering Foundation, began to study the psychology of labor troubles.

"Dr. Southard was the kindest and most considerate of men, never too busy or preoccupied to help others in little ways or to share with them their deepest interests and sorrows. All his professional assistants were also his devoted friends. Their work was suggested, encouraged and forwarded by him in every possible way for he preferred their success and the recognition which it brought to anything directly accruing to himself. Indeed, his own interests, his own profit was the thing that interested him least. He was far too busy to make money. He refused lucrative consultations and high-salaried positions because he preferred to devote himself to research for the good of humanity."

The following letter was sent to Mrs. Southard by Governor Coolidge of Massachusetts:

"It was with a deep feeling of sorrow that I learned of the sudden death of your distinguished husband. It is a loss not only to his family and friends, but to the Commonwealth which he so faithfully served. His life was given in the service of Massachusetts, and as Chief Executive, personally and on behalf of the State, I want to express keenest appreciation of that service.

We all have a just pride in Dr. Southard's achievements. The service he rendered was priceless and will endure for all time. He brought in his great life credit to the University whose name is honored by his work, and credit to all of his many colleagues in the great field of human endeavor. His three years of service in charge of the pathological department in one of our large state hospitals was but an earnest of what he was to do when called to the larger field in charge of like departments in similar hospitals all over the Commonwealth. The psychopathic department of the state hospital, which was a pioneer institution whose foundation was due largely to his energy and foresight, had the good fortune of having him as its director. It became, under his direction,

of great value to the Commonwealth and exerted a profound influence upon the policies in this line of work of the other states of the Union. Dr. Southard's labors in directing the work of the Massachusetts Psychiatric Institute embraced the entire work of the Commonwealth in this field of usefulness. His service in the World War as Major in the Chemical Warfare Service made the Psychopathic Hospital of Massachusetts a center of instruction in nervous and mental diseases for those examining officers on whose work and learning depended so much the morale of our armies. By his valued published results and by public addresses, Dr. Southard did much to maintain and extend the leadership of Massachusetts in humane and intelligent care of the mentally afflicted.

Dr. Southard will be missed for his unfailing good fellowship and sense of humor, his keenness to see and quickness to execute, and his sympathetic and practical way of applying science to the common welfare. He possessed in a large degree a trained, learned and capable mind for scientific research. He was indefatigable in his work of helpfulness. Only recently Dr. Southard expressed clearly his estimate of the value of work, when he said: 'Pay dirt is never very interesting, but it is out of pay dirt, washed many times, that the little grain of gold finally comes.' He has built a lasting monument to his memory, and in the minds and hearts of all his fellow-men he will always be a source of inspiration for those seeking to do the greatest good for the Commonwealth and the nation.

In expressing personally and on behalf of the Commonwealth the deepest sympathy for this great loss that has come to you, I hope that the memories of the great work he was able to do for the human race will be of comfort and strength to you and your family in bearing this affliction.

Very truly yours,

CALVIN COOLIDGE."

#### WARREN RANDALL GILMAN, M.D.

DR. WARREN RANDALL GILMAN, a Fellow of the Massachusetts Medical Society, died at his home in Worcester, May 2, 1920, after a long illness from malignant disease of the abdomen. He was born in Boston, December 14, 1861, and was graduated from Harvard College in 1884. After taking his M.D. at Harvard Medical School in 1888, he served as house officer at the Boston City Hospital and at the Boston Lying-in Hospital, then settling in Worcester, where he was on the out-patient staffs of the Worcester City and Memorial Hospitals. Dr. Gilman had a general practice and was popu-

lar both in the profession and out of it, being president at one time of the Worcester Harvard Club and a member of one of the leading private medical clubs. He is survived by his widow, daughter of Simeon E. Baldwin of New Haven, and a son and daughter. He was a brother of the Rev. Bradley Gilman of Boston.

#### ÉMILE POIRIER, M.D.

DR. ÉMILE POIRIER died at his home in Salem, April 29, 1920, at the age of 64 years.

He was born in Canada and graduated from Nicolet College and received his M.D. from Laval University College of Medicine in 1881. Moving from Quebec, he settled in Salem and joined the Massachusetts Medical Society in 1887. Dr. Poirier served on the Salem Rebuilding Commission appointed by Governor Walsh, and belonged to the Massachusetts Medical Society, Massachusetts French Historical Society, Essex South District Medical Society, of which he recently was president, Veragua Council, Knights of Columbus, and the St. Jean de Baptiste Society of Salem.

Dr. Poirier leaves five sons and two daughters. Mrs. Poirier died several years ago.

#### Miscellany.

#### EDUCATION AND RECREATION IN THE ARMY.

BY MAJOR GENERAL WILLIAM G. HAAN,

*Assistant Chief of Staff, and in Charge of Education and Recreation Work in the Army.*

THAT education and recreation as applied to the new Army has passed the experimental stage and is now a vital factor in the training of the soldier was shown at a convention of Army educational officers, held at Camp Zachary Taylor, near Louisville, Kentucky, on December 9, 10 and 11.

Early in the year, the War Department actuated by a deep sense of responsibility felt towards the millions of men brought into the service during the war, as well as by the astounding facts as to illiteracy and physical condition of the young men of the country as shown by draft statistics, and the excellent work done by the Commission on Education and Special Training, had conceived an army built up on a new plan. It was proposed to make

the army not only a military force to be trained and ready in time of national emergency, but a great educational institution where young men of the best mental, moral and physical conditions, and with the highest ideals of patriotic citizenship would be produced.

This plan was realized, in a measure, when the Congress appropriated the sum of \$2,000,000 to be devoted to this purpose during the fiscal year 1920. Accordingly, in September of this year instructions went forward to the commanding generals of all divisional camps and of territorial departments, who at once appointed on their staffs, officers known as Education and Recreation Officers to assume direct charge of the work. Each officer has associated with him at least one civilian expert in educational affairs, who furnishes assistance and advice in establishing schools and manual training classes.

But it remained for the Camp Taylor Convention, called by the Secretary of War in order that the work in general might be coördinated and rough places smoothed out, to show that the army is now in reality a great training school where the mothers of our young Americans will be glad to see their boys go. This idea of the army as a vast university in khaki is admittedly hard to conceive, but nevertheless the thing has been accomplished right before our eyes.

No longer is an army merely concerned in the making of a recruit into an efficient fighting man, by giving him the prescribed system of military training only for a few hours of the day and leaving him almost entirely to his own resources for the remainder of the day. It now assumes responsibility for the entire twenty-four hours of his day, and sees every portion is gainfully spent in useful study or helpful recreation. In the soldier's life, education and recreation now have equal places with military training, and are definitely scheduled in the programme of daily work.

All training, whether purely military or educational, has as its main object the development of the soldier's mind to make him a responsible thinking human being. Every soldier, however poorly he may be educated, or however limited his experience, has still a thinking mind, and that mind is active practically all the time. Such a man is perhaps incapable at the moment of looking at affairs in a broad sense, but the object of all training must be to guide that mind in the direction of right thinking. In order to accomplish this the instructor himself must be able to estimate about what are the channels of thought in the mind of the men being trained, in order that he may so conduct his own part of the work as to gain the confidence of the men he is instructing or leading.

In developing the soldier's mind the most rapid progress is made by placing upon the man, as early as practicable, as much responsibility as he can stand. This placing of responsibility on the man stimulates his pride, raises his self-respect, and urges him to better

effort. This is applicable in all kinds of training. It is character building, frequently called moral training, and the most effective means of stimulating self-development.

Every soldier, down to and including the last recruit, will sooner or later become a leader in a smaller or greater sense. In battle, as battles are now necessarily conducted, direct responsibility very frequently goes out of the hands of the officers, and small groups of men must accomplish objectives by themselves; hence leadership must be assumed by some or all of these men. Any one of them may be placed in a position where he must act independently and make his own decision on his own responsibility, which requires thinking and acting on his own judgment. It requires leadership. And it is to develop these latent qualities of leadership that this educational programme has been inaugurated.

New recruits are inclined to look on their officers from the very beginning with respect and as thoroughly conversant with their duties. It is very important that this natural impression should be maintained and improved, but this cannot be done unless the leaders are in the habit of thinking correctly and justly in all matters, and acting accordingly. This is necessary to gain and maintain the confidence and respect of the men. When it has been fully accomplished, then most of the small difficulties disappear. There will be a high state of morale in the command, and wherever we find a high state of morale we always find a high state of discipline, instruction and consequent usefulness.

Officers of our future armies will be required not only to be thoroughly trained in a professional sense but must also have that human quality which comes only through a real interest felt for the welfare of the men under their command. They must not only be military instructors to the men, but also their leaders in all sports and recreation. Experience of the larger colleges and universities has shown that a certain amount of sport and recreation is a necessary part of the student's life, and as the army is now a great university in every sense of the word, and each man composing it a student, recreational activity will be a part of its training. Here the army chaplain enters as an important factor in the handling by military means alone of all the camp activities formerly furnished by the Y. M. C. A., Knights of Columbus, etc., and the Americanization of aliens in the army.

Under the system of education now in force it is possible for men to receive instruction so as to fit them to be carpenters, blacksmiths, pharmacists, dental assistants, engine workers, mechanics, draftsmen, stenographers, truck gardeners, motor drivers, repair men, telegraphers, radio and telephone operators, etc. Such educational subjects as English, geography, mathematics, United States history and



modern languages are also taught. Of course, at the present stage of the game it is not possible to give instruction in all subjects at any one camp or post, but so far as practicable, the desires of the enlisted man as to the courses to be taken by him will be met.

A certificate will be given by the local commanding officer or school officer to each man who successfully completes a course, indicating that he has satisfactorily completed the course studied. A standard War Department certificate will later be adopted, and the possession of such a certificate by a soldier who has been discharged with a character of "Excellent" will be sufficient recommendation to a civilian employer as to the qualifications of the discharged soldier for employment.

On the other hand, it is highly important that the men themselves take the thing seriously and realize that the Government is concerned not only in making trained soldiers of them, but also making of them self-supporting and self-respecting members of the communities to which they will return on discharge.

This work is unique in the history of the Government, and highly important in showing the trend of the army in facing the new problems developed by the World War. It will result in making the army in time of peace a more valuable factor in the life of the Nation by producing men of best possible type, having a good general education, possessing a useful trade, but, above all, thoroughly trained in moral character and the duties and responsibilities of good citizenship.

### The Massachusetts Medical Society.

#### NEWS FROM THE DISTRICT MEDICAL SOCIETIES.

The Berkshire District Medical Society reports the following Fellows who served in the World War:

##### ENTERED SERVICE

1917	Contract Surgeon, Lt. Vanderpoel	Adrian, Lenox
1917	Captain Louis D. Barnes,	Williamstown
1917	Lieut. Michael J. Carroll,	Lanesboro
	(Died at Newport, R. I., Sept. 29, 1918.)	Lenox
1917	Major Robert J. Carpenter,	North Adams
1918	Capt. George L. Curran,	North Adams
1917	Capt. Isaac S. F. Dodd,	Pittsfield
1918	Major Frederic H. Howard,	Williamstown
1917	Capt. Thomas Littlewood,	Pittsfield
1917	Major William J. Lally,	Pittsfield
1918	Lieut. Norman B. McWilliams,	Williamstown
1917	Lieut. Austen F. Riggs,	Stockbridge
1917	Contract Surgeon, Lt. Silas N. Parks,	West Stockbridge
1917	Capt. Harry A. Schneider,	Pittsfield
1917	Major John A. Sullivan,	Pittsfield
1917	Capt. Harry J. Tate,	Pittsfield
1918	Lieut. John B. Thomas,	Pittsfield
1918	Red Cross, Capt. George H. Thompson,	North Adams
1917	Capt. Melvin H. Walker,	Pittsfield
1917	Capt. Charles W. Wright,	North Adams
1918	Red Cross, Alfreda B. Withington,	Pittsfield

1916 British Army, Major Winford O. Wilder, Pittsfield  
 On Local Draft Board—Selective Service Law:  
 District No. 1. R. Delos Canedy, North Adams  
 (Not a member of Massachusetts Medical Society)  
 District No. 2. Harry B. Holmes, Adams  
 District "City of Pittsfield," Henry Colt, Pittsfield  
 District No. 3. Clifford S. Chapin, Great Barrington

### Correspondence.

#### DUCTLESS GLAND IN U. S. SOLDIERS DURING THE EUROPEAN WAR.

Mr. Editor:

Being interested in material on diseases of the glands of internal secretion in U. S. soldiers in our army camps and at the front during the European War, I should feel much indebted to any physician who has served as a medical officer in the Army during the war, who might be able to supply me with any information in regard to this matter, particularly statistical relations, sermiology, the incidence of those diseases in drafted men and in enlisted men who were subsequently on duty, and the measures taken in dealing with such cases. Any help I may receive in this matter will be highly appreciated and acknowledged.

JAMES ROBB CHURCH,  
 Colonel, Medical Corps, U. S. Army,  
 Secretary-Treasurer.

The Association of Military Surgeons,  
 U. S. Army Medical Museum, Washington, D. C.  
 May 11, 1920.

#### NOTICES.

MASSACHUSETTS SOCIETY OF EXAMINING PHYSICIANS.  
 —The spring meeting of the Massachusetts Society of Examining Physicians at "Wardhurst," Lynnfield Centre, Mass., on Thursday, May 27, at 6.30 P. M. Dinner, \$3.00.

Subject of the evening: "Different Phases of Workmen's Compensation."

Speakers: Dr. Donoghue, Dr. Cotton, Dr. Leonard, Dr. Cornwall, Dr. Schubmehl, Dr. Marshall, Dr. Phipps, and Dr. Coues.

WILLIAM PEARCE COUES, M.D.,  
 Secretary.

SCHOOL PHYSICIANS' MEETING.—Dr. Max A. Goldstein of St. Louis, Mo., has accepted an invitation to address the school physicians in the Abraham Lincoln School, Arlington street, Boston, on Friday, May 28, at 4 P. M. The subject of his address will be "The Deaf Child." Members of the medical profession are invited to attend.

#### RECENT DEATHS.

DR. ÉMILE POIRIER died at his home in Salem, on April 29, 1920. Dr. Poirier was born at St. Gregoire of Nicolet, Canada, on December 8, 1856, the son of Mr. and Mrs. Esdras Poirier. He was graduated from Nicolet College and received his medical degree from Laval University Medical School of Quebec City.

DR. CHARLES H. NEWHALL died at his home in Newton Highlands on May 11, 1920. Dr. Newhall was born in Lincoln on October 24, 1838, the son of the Reverend Ebenezer Newhall and Sarah Clark Newhall. He served as a surgeon in the Civil War. Dr. Newhall is survived by one sister, Miss Sarah S. Newhall.